Analysis of State Medicaid Program Characteristics

1983

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FOREWORD

For many years, Medicaid policy-makers, analysts and researchers lacked a single comprehensive source of information regarding the policy and operating characteristics of State Medicaid programs. In response to this need, the Health Care Financing Administration(HCFA), in September of 1981, contracted with La Jolla Management Corporation of Rockville, Maryland to develop such a data base. The final product would be in an easy-to-read format for reference by States, Federal agencies, the Congress and the Public.

The first task undertaken was to identify and then to organize into logical groupings the policy and operating characteristics of State Medicaid programs of most interest to Federal and State administrators. The second task involved finding an efficient and reliable means to collect and validate the information to be included in the data base. The method chosen was to abstract selected information from Medicaid State plans, other HCFA data sources, and from files maintained by the Social Security Administration. This was done and the resulting State profiles were sent to each State for verification and correction. Since Federal source files were sparce on State reimbursement methods and rates for various provider types, a special survey was conducted under the auspices of the National Governors' Association with assistance from the Intergovernmental Health Policy Project. The resultant State characteristics profiles were compiled and documented in a report titled, Analysis of State Medicaid Program Characteristics, 1982. The 1982 report contained reliable and comprehensive profiles of all State programs, along with supporting narrative that explained sources of inter-State variations.

This volume contains the results of the 1983 update of the original survey. This update benefited from a number of lessons learned in the course of preparing the 1982 report. Hence, the information contained in this report differs from that presented in the 1982 report.

State Medicaid program profiles are current as of March, 1983. Whereas the 1982 profiles largely reflected a pre-Omnibus Budget Reconciliation Act of 1981 environment, this current 1983 profile reflects many of the changes made to the programs using the flexibility given to States by the Act.

La Jolla Management Corporation wishes to acknowledge the assistance of all State Medicaid agencies and their staffs, especially those States that volunteered to provide special assistance in the early stages of the study. They were: California, Michigan, New Jersey, New York, and Virginia. We would also like to thank the assistance of the National Governors' Association and the Intergovernmental Health Policy Project of the George Washington University. Both organizations helped us to collect and interpret data. A very special thanks goes to Don Muse, Ph.D., our HCFA Project Officer. The study benefited by his direction, encouragement and energy.

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December, 1983

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1. INTRODUCTION

This section provides the background and need for the data collected in this report and an overview of the content and scope of the Medicaid program characteristics data base.

1.1 BACKGROUND

Federal law permits considerable latitude in determining State Medicaid program characteristics. The most recent example is the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Recent Federal regulations also give States new flexibility in freedom of choice, institutional reimbursement, home and community-based services, and eligibility and service coverage for the medically needy. Interstate Medicaid program variations are likely to become even more diverse over the coming years as States mold new eligibility, service coverage, reimbursement and administrative policies.

The Health Care Financing Administration (HCFA) is currently charged with Federal administration of the Medicaid program; including the provision of accurate and up-to-date information on the current status of the program and the knowledge base needed to project future trends in program operations and service costs. Both HCFA and the State Medicaid Agencies need an improved understanding of how service utilization and expenditure patterns differ given various Medicaid program characteristics. This information is essential to improve the basis for future policy decisions which may contain costs without compromising access to quality care for those in need.

Various sources of State Medicaid program characteristics data range from State plans and statistical and other reports provided to HCFA, Aid to Families with Dependent Children (AFDC), and Supplementary Security Income (SSI). These various sources contain partial descriptions of State Medicaid programs. A complete or comprehensive description required abstracting selected information from a half dozen different sources and organizing the information for easy interpretation and ready access to a wide variety of users.

In recognition of this need, HCFA has sponsored three distinct but interrelated efforts to provide better information on the various State Medicaid program policies. The first was a grant to the National Governors' Association to periodically communicate with State Medicaid agencies and record what changes in program policies were being considered or proposed. This information source is qualitative and contains limited coverage of actual program policy changes. The second was a grant to the George Washington University Intergovernmental Health Policy Project. This effort has been a general surveillance of State legislative and regulatory changes in the entire health care arena. Both grants have identified and recorded selective changes of topical interest affecting State Medicaid programs. The third HCFA initiative was the development, automation and dissemination of a detailed and comprehensive data base on current Medicaid program characteristics. This file, constructed under this study, was 100 percent validated and automated for easy update and report generation. The file was compiled for Medicaid program characteristics as of February 7, 1982 and again as of March 31, 1983. This latter compliation is the subject of this report.

1.2 OVERVIEW OF THE CHARACTERISTICS DATA BASE

The purpose of this HCFA contract was to design and implement a data system which would, on a selective basis, unify selected State Medicaid program characteristics into a single source. This data base has been updated for 1983. The file contains the following types of information on a State-by-State basis:

a. State eligibility policy for mandatory, optional and medically needy groups (Section 3.0 of this report);

b. Service coverage and limitations (Section 4.0);

c. Provider reimbursement policies (Section 5.0);

d. Administration and finance characteristics (Section 6.0);

e. Demographic, economic and medical sector characteristics (Section (7.0); and

f. State-only programs (Section (8.0).

The computerized data base on Medicaid program characteristics is called the Program Characteristics File (PCF). It has been initialized by profiling State programs as they existed in February, 1982 and updated as of March 31, 1983. All data in the system has been verified with the States for maximum accuracy. The PCF is automated and linkable to other HCFA data sets such as the HCFA-2082 Medicaid Annual Statistical Reports and monthly HCFA 120 data set. Linkages can be made to other Federal and State data bases.

In summary, the program characteristics data base presented in this report has the following attributes:

- Identifies and classifies important program characteristic variables of interest to State administrators, researchers, financial analysts, the Congress, and the Public;
- Contains data validated by the States themselves for completeness and accuracy;
- Contains linkages to routine HCFA statistical data bases;
- Provides capability to produce descriptive reports on interstate variability among State program characteristics;
- Contains data items that are not strictly programmatic characteristics such as selected State demographic, economic and medical sector characteristics;
- Provides capability for update at annual intervals; and
- Exists in automated form to enable quick information retrieval of descriptive or analytical reports.

The current data in this report portrays the Medicaid programs as of March 31, 1983.

2. METHODOLOGY AND DATA SOURCES

This section discusses the methodology that was employed from the initial design of the project to the output of the final verified tables. Data sources, procedures, study scope and limitations, both implicit and explicit, are discussed.

2.1 METHODOLOGY OVERVIEW

This project began in September of 1981 with an overall goal to gather and document in a single source, selected characteristics of State Medicaid programs so that such information would be readily available to the States, HCFA, and others. This information will significantly improve the knowledge base for Medicaid program policy analysis and research. The steps that have been undertaken in this effort to date are:

- The identification, classification, collection, and validation of State Medicaid program characteristics of major interest to State Administrators, HCFA, the Congress, and the Public; and
- The computerization of the Program Characteristics File (PCF) data base.

These two steps have been completed for the Medicaid program as of February 7, 1982 and as of March 31, 1983. Details of program characteristics as of February 7, 1982 were discussed in a previous report entitled Analysis of State Medicaid Program Characteristics, 1982. This report is a presentation of program characteristics as of March 31, 1983.

2.1.1 Identification, Collection and Validation of State Medicaid Program Characteristics

Data were collected for five areas of program characteristics for both 1982 and 1983. Those areas include eligibility policies, service coverage and limitation policies, provider reimbursement policies, administration and finance policies, and demographic, economic and medical sector parameters.

The data collection format for each area was updated in 1983 to encompass any program changes and any additions that were deemed important as well as feedback received from users of the 1982 volume.

Data were updated/collected from four basic sources:

- Medicaid State Agencies;
- Updated pages to the Medicaid State Plans;
- Routinely collected HCFA data; and
- Routinely collected Bureau of the Census data.

Originally, Medicaid State Agencies were sent the data collection format with data correct as of February 7, 1982. They were asked to review the information and update it as of policies in effect on March 31, 1983. Details of the data collection format can be found in Volume II. Where data for a 12 month period were requested, Federal fiscal year data were provided if possible. All States responded in a timely manner with the exception of eleven representing 8.7 percent of all Medicaid expenditures. For those eleven States, the Regional HCFA offices were requested to send any State Plan updates that had been submitted during the time period February 7, 1982 - March 31, 1983. The information from those updates was abstracted and the 1982 data updated to reflect those changes.

HCFA data that are routinely collected were abstracted for the data set in both years. These data include such information as the Medicaid quality and control data, Medicaid costs for State administration and training, Medicaid vendor payments, and other information collected by HCFA. Data collected by the Bureau of the Census on State demographic and economic characteristics were also abstracted. Finally, data from the Food Stamps program and the Families with Dependent Children program were collected and abstracted from published sources.

As State updates were received, each section of each update was reviewed for completeness and logic. A State contact had been noted for each section and the contact person was telephoned as necessary to clarify any questions arising from the review.

2.1.2 Computerization of the Characteristics Data Base

An automated file to facilitate the storage and manipulation of the detailed tabulations and reports was built for the 1982 data. This file was expanded and updated to accommodate the 1983 data. As verified detailed State profiles were returned from each State, the data were coded and entered into the system. These data were then edited and verified. Table formats were designed and draft computer generated tables were produced. The final version of these tables appear in this volume and the narrative describes the information contained in each table.

2.2 SCOPE AND LIMITATIONS

The data collection effort covered all States with Medicaid programs and the District of Columbia; Arizona is the only State that does not have a program although it currently has a united demonstration project funded of HCFA. Thus, data for 50 jurisdictions were collected.1/ There are four territories that have Medicaid programs - Guam, the Marianna Islands, Puerto Rico, and the Virgin Islands. These four programs were judged to be unique and they are not covered in the scope of this project.2/

Definitions of Medicaid program terms given in the text of this document are from the Code of Federal Regulations (CFR), Section 42. Data on total Medicaid expenditures, Medicaid expenditures by service, total Medicaid recipients, and Medicaid recipients by eligibility category are for FY 82 and are from the HCFA-2082 data set.

1/ To simplify the language throughout this report, the District of Columbia is classified as a State and referred to as such.

2/ Expenditures for the Medicaid programs in the territories were overwhelming those of the Puerto Rico program ($116 million in 1982). A description of this program can be found in Pagan-Berlucchi and Muse, Health Care Financing Review, Summer 1983.

The data were collected over the time period of March - September, 1983. March 31, 1983 is the date for which the data were verified to be accurate. The data presented are a snapshot picture of the Medicaid program on March 31, 1983 insofar as what was in effect at that point in time. However, the effective date of a policy does not necessarily coincide with the implementation date. Additionally, policies are occasionally challenged in court and implementation of those policies withheld pending the ruling.

There are several basic issues that should be pointed out concerning terminology; to include:

- Definitions;
- Classification of items; and
- Standardization.

Definitions are given in the CFR for an extensive list of terms, e.g., inpatient psychiatric services, categorically needy, medically needy, etc. However, even with these definitions, there is room for varying interpretations and there are a host of terms which have not been defined by the CFR. Because of the definitional problems and other factors, the classification of items is not always consistent across States; for example, some States might include a limitation on family planning services under inpatient hospital services, another State might include it under physician services, and yet another under clinic services. In reporting limitations, some States report everything included and other States report everything excluded. To further complicate matters, States do not always make a distinction between Federal requirements and State requirements. In our synthesis and compilation of the data we have attempted to eliminate those items reported by States that apply to all States as Federal requirements and to include only those items that are State requirements. However, the text includes discussions of the general Federal limitations.

Standardization of data across 50 State Medicaid programs is handled reasonably well for data that are required to be reported on a regular basis to HCFA. However, data that are not required to be reported to HCFA are difficult to obtain and standardize - a point in case is the particularly troublesome State-only program data. In summary, we feel that the data collection effort has yielded generally accurate data and the issues discussed here have, for the most part, not been serious limitations.

3. ELIGIBILITY

This section presents detailed information on Medicaid eligibility for 49 States and the District of Columbia. The eligibility provisions for this program are among the most complex of all assistance programs given its interrelationships with the Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) programs and the amount of flexibility accorded States through its regulations. At a minimum, States must cover all persons who receive cash payments from either the AFDC or, in most cases, the SSI program. States have the option of extending Medicaid coverage to specified groups of individuals known as the optionally categorically needy and to the medically needy. The following tables and narrative describe the standards States use to determine who is eligible for Medicaid as categorically needy and as medically needy.

3.1 MANDATORY ELIGIBILITY

States that establish Medicaid programs must provide for medical assistance to the categorically needy. Generally, these are persons who are both categorically related (eligible as aged, blind, disabled, or a member of a family with children deprived of the support of at least one parent) and financially eligible on the basis of income and resources. The categorically needy include all cash recipients of the AFDC, certain other AFDC related groups, most cash recipients of SSI program, and other SSI related groups. The mandatory eligibility requirements and groups are discussed below under Families with Dependent Children and Supplemental Security Income.

3.1.1 AFDC Mandatory Eligibility

A State must provide Medicaid to all individuals receiving AFDC (42 CFR 435.110). An individual receiving AFDC is defined to be one whose needs are included in determining the amount of the AFDC payment. Each State has the

latitude within its AFDC program to include or exclude three specific groups: families with unemployed parents, pregnant women with no other eligible children, and children age 18 regularly attending school. However, if a State extends AFDC coverage to these groups, it must extend Medicaid coverage as well. Table 3.1.1(A) displays the States covering these groups in their AFDC State Plan.

Twenty-three States include families with an unemployed parent in the coverage of their State Plan. Those 23 States have 73.8 percent of the total number of AFDC cash recipients in all States. Pregnant women with no other eligible children were included by 29 States in their AFDC State Plans. When a State chooses this option, AFDC regulations allow eligibility for AFDC cash assistance for only the last four months of the pregnancy. The 29 States account for 63.4 percent of the total number of AFDC cash recipients. Thirty-seven States include coverage of children age 18 regularly attending school. The school must be a secondary school or the equivalent of technical or vocational training. Prior to OBRA 81, attendance at college could be used to qualify such individuals. However, per the provision of the act, college attendance can no longer be used to qualify an individual over age 18.

States must deem one group and can choose to deem two other groups of individuals to be AFDC recipients (42 CFR 435.115). If individuals are deemed to be AFDC recipients, the State must make them eligible for Medicaid. All individuals who are denied AFDC cash payment solely because the payment would be less than $10 a month must be deemed recipients of AFDC. This is displayed on Table 3.1.1(A) showing 50 States and 100% of the total AFDC cash recipients. A State can choose to deem certain pregnant women AFDC recipients and thereby extend Medicaid eligibility as soon as pregnancy is medically verified even though eligibility for AFDC cash assistance would not be granted until the sixth month of pregnancy. Thirty-one States deem certain pregnant women to be AFDC recipients. Those 31 States account for 72.5 percent of the total AFDC cash recipients. States may also choose to deem participants of work supplementation programs to be AFDC recipients. Three States, Hawaii, Kentucky and Vermont have choosen to do so and thus these recipients must be made eligible for Medicaid.

Table 3.1.1(A)

MANDATORY MEDICAID ELIGIBILITY GROUPS: FAMILIES WITH DEPENDENT CHILDREN

STATE	AFDC Cash Recipients	AFDC STATE PLAN INCLUDES: Families with Unemployed Parents	Pregnant Women with No Other Eligible Children	Children Age 18 Regularly Attending School	DEEMED RECIPIENTS OF AFDC: Those Denied Cash Because Amount Would Be < $10.00	Pregnant Women	Work Supplement Program Participants	Families That Were Terminated Due to Increased Earnings/Hours	Those Ineligible for AFDC Due To Rules That Do Not Apply Under Title XIX, such as: Lien Law	Other
ALABAMA	X	-	-	-	X	X	-	X	-	-
ALASKA	X	-	X	-	X	X	-	X	-	X
ARKANSAS	X	-	-	-	X	-	-	X	-	X
CALIFORNIA	X	X	X	X	X	X	-	X	-	-
COLORADO	X	X	X	X	X	X	-	X	-	-
CONNECTICUT	X	X	X	X	X	X	-	X	X	-
DELAWARE	X	X	X	-	X	-	-	X	-	X
DIST COLUMBIA	X	X	X	X	X	X	-	X	X	X
FLORIDA	X	-	X	-	X	X	-	X	-	X
GEORGIA	X	-	-	-	X	-	-	X	X	X
HAWAII	X	X	X	X	X	X	X	X	X	-
IDAHO	X	-	X	X	X	X	-	X	-	X
ILLINOIS	X	X	-	X	X	-	-	X	-	-
INDIANA	X	-	-	-	X	-	-	X	-	-
IOWA	X	X	-	-	X	X	-	X	-	X
KANSAS	X	X	X	X	X	X	-	X	-	X
KENTUCKY	X	-	-	X	X	X	X	X	-	X
LOUISIANA	X	-	X	X	X	-	-	X	-	-
MAINE	X	-	-	X	X	-	-	X	-	-
MARYLAND	X	X	X	X	X	X	-	X	-	-
MASSACHUSETTS	X	X	X	X	X	X	-	X	-	X
MICHIGAN	X	X	X	X	X	X	-	X	-	-
MINNESOTA	X	X	X	X	X	X	-	X	-	X
MISSISSIPPI	X	-	-	-	X	X	-	X	-	-
MISSOURI	X	X	-	X	X	-	-	X	-	-
MONTANA	X	-	X	X	X	X	-	X	-	-
NEBRASKA	X	X	X	X	X	X	-	X	-	X
NEVADA	X	-	X	X	X	-	-	X	-	-
NEW HAMPSHIRE	X	-	-	-	X	-	-	X	-	X
NEW JERSEY	X	X	-	X	X	-	-	X	-	-
NEW MEXICO	X	-	X	X	X	-	-	X	-	-
NEW YORK	X	X	X	X	X	X	-	X	-	-
N CAROLINA	X	-	-	X	X	-	-	X	-	X
N DAKOTA	X	-	X	X	X	X	-	X	-	X
OHIO	X	X	X	X	X	X	-	X	-	-
OKLAHOMA	X	-	-	X	X	-	-	X	-	-
OREGON	X	-	X	X	X	X	-	X	-	X
PENNSYLVANIA	X	X	-	X	X	X	-	X	X	X
RHODE ISLAND	X	X	X	X	X	-	-	X	-	-
S CAROLINA	X	-	-	X	X	X	-	X	-	X
S DAKOTA	X	-	-	-	X	-	-	X	-	-
TENNESSEE	X	-	X	-	X	X	-	X	-	-
TEXAS	X	-	-	X	X	-	-	X	-	-
UTAH	X	-	X	X	X	X	-	X	-	X
VERMONT	X	X	-	X	X	X	X	X	-	-
VIRGINIA	X	-	-	X	X	-	-	X	-	X
WASHINGTON	X	-	X	X	X	X	-	X	-	X
W VIRGINIA	X	X	-	-	X	-	-	X	-	-
WISCONSIN	X	X	X	X	X	X	-	X	X	-
WYOMING	X	-	X	X	X	X	-	X	-	-
TOTAL STATES	50	23	29	37	50	31	3	50	6	22
% RECIPIENTS FOR CATEGORY	100	73.8	63.4	87.0	100	72.5	2.2	100	12.4	27.8

A State must continue to provide Medicaid for four months to all members of the AFDC program if they lose AFDC solely because of increased income from employment or increased hours of employment (42 CFR 435.112). Additionally, the family must have received AFDC for three or more of the six months immediately preceeding the month in which it became ineligible; at least one member of the family must be unemployed throughout the four-month period; and the four-month period must begin on the date of AFDC termination. This mandatory eligibility group is shown on Table 3.1.1(A) with 50 States providing coverage.

Individuals who are ineligible for AFDC coverage because of requirements that do not apply under Medicaid must be provided with Medicaid services. One type of rule used in determining AFDC eligibility that is specifically prohibited under Title XIX is lien laws (42 CFR 435.113). Section 1902(a)(18) of the Social Security Act prohibits the State from placing a lien against a recipient's property and restricts the use of adjustments and recoveries against recipients prior to his or her death for Medicaid claims paid on the individual's behalf, except when the lien was the direct result of a court judgment for claims incorrectly paid. Six States have lien laws that are used in determining AFDC eligiblity that are prohibited under Medicaid. Eighteen States have other rules used to determine AFDC eligibility that do not apply under Medicaid. Examples of other rules include applicants who refuse to provide Social Security numbers, refuse to register for a work incentive program, and refuse to deem step parents income. The 22 States that have "other laws" account for 27.8 percent of the total number of AFDC cash recipients.

There are certain individuals that must be provided Medicaid because they are members of a 1972 pass-through group (42 CFR 435.114). These are individuals who would currently be eligible for AFDC except that the increase in Old Age, Survivors, and Disability Insurance (OASDI) under Title II of the Social Security Act raised their income over the limit allowed under AFDC. The individuals must meet the following criteria:

- In August 1972, the individual was entitled to OASDI;
- The individual was receiving AFDC or was eligible to receive AFDC, or would have been eligible for AFDC if not in a medical institution or ICF, and the Medicaid plan covered this optional group; and

- The individual meets all current SSI requirements except for the requirements to file an application or would meet all current requirements if not in a medical institution or ICF.

Table 3.1.1 (B) displays the status of the 1972 "pass-through" groups. Twenty-five States cover individuals that would have been eligible for AFDC if they had applied and the State Medicaid plan covered this optional group in August 1972. Few, if any, individuals from these 1972 pass-through groups should still be eligible. These 25 States account for 68.2 percent of the total number of AFDC cash recipients. Thirty-four States cover individuals that would have been eligible for AFDC if they were not in a medical institution and the Medicaid plan covered this group. These 34 States account for more than 70 percent of the total AFDC cash recipients. Of the 34 States, four provide Medicaid to institutionalized individuals in medical institutions and not to individuals in ICFs.

One final FDC mandatory eligibility group is adoption assistance and foster care children (Table 3.1.1 (B)). The State agency must provide Medicaid to children from whom adoption assistance or foster care maintenance payments are made under title IV-E (42 CFR 435.118).

States determine the income standards for each assistance and Medicaid eligibility. Tables 3.1.1(C - E) presents the annual need, payment, and maximum payment standards for AFDC families by State. Each State determines the State's general definition of a "needy person." The need standard is then compared with the income available to the family unit (after excluding certain disregards) to determine AFDC eligibility within that State. The need standard is the amount of money a State determines essential to meet a minimal standard of living in that State for a family of a specified size. In general, the standard provides for basic items such as food, clothing, shelter, fuel and utilities, personal care items and household supplies, and in certain cases, special or recurrent needs. Some States vary the need standard to reflect differences in actual costs within the State, by season, or on the basis of age of the child.

Table 3.1.1(B)

MANDATORY MEDICAID ELIGIBILITY GROUPS: FAMILIES WITH DEPENDENT CHILDREN

STATE	1972 "PASS-THROUGH" GROUPS: Those Who Would Be Eligible But for Increased OASDI Benefits — Eligible but Didn't Apply	In Institutions — Med Insts	In Institutions — Not ICFs	State Makes Adoption Assistance or Foster Care Payments for Child Under Title IV.E
ALABAMA	-	-	-	X
ALASKA	X	X	-	X
ARKANSAS	-	-	-	X
CALIFORNIA	X	X	X	X
COLORADO	X	X	-	X
CONNECTICUT	X	X	X	X
DELAWARE	-	X	-	X
DIST COLUMBIA	-	-	-	X
FLORIDA	-	X	-	X
GEORGIA	X	-	-	X
HAWAII	-	X	X	X
IDAHO	X	X	-	X
ILLINOIS	-	-	-	X
INDIANA	-	-	-	X
IOWA	-	X	-	X
KANSAS	-	-	-	X
KENTUCKY	-	X	-	X
LOUISIANA	X	X	-	X
MAINE	-	-	-	X
MARYLAND	X	X	-	X
MASSACHUSETTS	X	X	-	X
MICHIGAN	X	-	-	X
MINNESOTA	X	X	-	X
MISSISSIPPI	X	X	-	X
MISSOURI	-	-	-	X
MONTANA	X	X	-	X
NEBRASKA	-	-	-	X
NEVADA	X	X	-	X
NEW HAMPSHIRE	-	X	X	X
NEW JERSEY	-	X	-	X
NEW MEXICO	-	X	-	X
NEW YORK	X	X	-	X
N CAROLINA	-	-	-	X
N DAKOTA	-	-	-	X
OHIO	X	X	-	X
OKLAHOMA	X	X	-	X
OREGON	X	X	-	X
PENNSYLVANIA	X	X	-	X
RHODE ISLAND	X	X	-	X
S CAROLINA	-	X	-	X
S DAKOTA	-	-	-	X
TENNESSEE	-	X	-	X
TEXAS	-	-	-	X
UTAH	X	X	-	X
VERMONT	X	X	-	X
VIRGINIA	X	X	-	X
WASHINGTON	X	X	-	X
W VIRGINIA	-	-	-	X
WISCONSIN	X	X	X	X
WYOMING	-	X	-	X
TOTAL STATES	25	34	5	50
% RECIPIENTS FOR CATEGORY	68.2	71.6	19.8	100

The need standards for States for July 1981 - June 1982 are displayed on Table 3.1.1(C) for families with one child, one adult, family of two and family of four. States are allowed a great deal of latitude in setting their standards and no two States have identical standards. The payment standards for States as of July 1981 are found on Table 3.1.1(D) for the same family units. The payment standard determines the extent to which the State cash assistance program will meet the need for a minimal standard of living. Thirty States set the payment standard lower than the need standard for at least one size family unit. It should be noted that a State meeting less than full need but having a high need standard may provide a substantially higher level of assistance than a State meeting full need under a low need standard.

Maximum payment standards are also established by each State and found on Table 3.1.1(E) for family units of one, two, and four. The maximum payment is the amount paid for basic needs under State law. For a family with no income, this is the AFDC payment. For the majority of States that maximum is equal to the payment standard for each family unit size. However, in three States the maximum payment level for at least one family unit size was below the payment standard. The three States (Indiana, Mississippi, and West Virginia) had maximum payment levels established below the payment standard levels.

3.1.2 SSI Mandatory Eligibility

Prior to 1974, States had the same authority to set cash assistance and Medicaid eligibility standards for the aged, blind, and disabled, as they had for the AFDC population. However, with the enactment of the Social Security Amendments of 1972 (P.L. 92-603) the Federal program of SSI was established and the States were no longer required to cover all aged, blind, and disabled cash recipients. States can choose from the following options:

- States can make all SSI recipients eligible for Medicaid; or
- States can make all SSI recipients eligible for Medicaid and in addition provide Medicaid to individuals receiving only optional State supplements; or
- States can limit Medicaid eligibility to individuals who meet requirements that are more restrictive than those under SSI. States exercising this option (209(b)) must deduct SSI, optional State supplements and incurred medical expense from income in determining Medicaid eligibility. Thus, there is no fixed income ceiling under this option.

Table 3.1.1(C)

AFDC STANDARDS FOR BASIC NEEDS

	NEED STANDARD											
	One Child			One Adult			Family of Two			Family of Four		
	Highest	Lowest	Difference	Highest	Lowest	Difference	Highest	Lowest	Difference	Highest	Lowest	Difference
ALABAMA	$192	-	-	$192	-	-	$288	-	-	$480	-	-
ALASKA	$238	-	-	$359	-	-	$597	-	-	$751	-	-
ARKANSAS	$98	-	-	$98	-	-	$193	-	-	$273	-	-
CALIFORNIA	$331	-	-	$331	-	-	$544	-	-	$801	-	-
COLORADO	$110	-	-	$234	-	-	$307*	-	-	$470**	-	-
CONNECTICUT	$134	-	-	$134	-	-	$358	-	-	$517	-	-
DELAWARE	$141	-	-	$141	-	-	$197	-	-	$312	-	-
DIST COLUMBIA	$370	-	-	$370	-	-	$462	-	-	$715	-	-
FLORIDA	$221	$126	$95	$221	$126	$95	$297	$202	$95	$468	$333	$135
GEORGIA	$303	$202	$101	$303	$202	$101	$459	$306	$153	$648	$432	$216
HAWAII	$297	-	-	$297	-	-	$398	-	-	$546	-	-
IDAHO	$365	-	-	$365	-	-	$446	-	-	$554	-	-
ILLINOIS	$169	$126	$43	$243	$210	$33	$372	$345	$27	$660	$613	$47
INDIANA	$185	-	-	$185	-	-	$247	-	-	$363	-	-
IOWA	$154	-	-	$154	-	-	$336	-	-	$482	-	-
KANSAS	$216	-	-	$216	-	-	$280	-	-	$385	-	-
KENTUCKY	$133	-	-	$133	-	-	$162	-	-	$235	-	-
LOUISIANA	$190	-	-	$190	-	-	$363	-	-	$620	-	-
MAINE	$121	-	-	$211	-	-	$332	-	-	$564	-	-
MARYLAND	$166	-	-	$166	-	-	$291	-	-	$450	-	-
MASSACHUSETTS	$260	-	-	$260	-	-	$330	-	-	$467	-	-
MICHIGAN	$304	$249	$55	$304	$249	$55	$387	$332	$55	$538	$483	$55
MINNESOTA	$210	-	-	$158	-	-	$368	-	-	$520	-	-
MISSISSIPPI	$171	-	-	$171	-	-	$244	-	-	$327	-	-
MISSOURI	$145	-	-	$145	-	-	$250	-	-	$365	-	-
MONTANA	$256	-	-	$256	-	-	$337	-	-	$513	-	-
NEBRASKA	$218	-	-	$218	-	-	$280	-	-	$420	-	-
NEVADA	$56	-	-	$173	-	-	$229	-	-	$341	-	-
NEW HAMPSHIRE	$241	-	-	$241	-	-	$292	-	-	$392	-	-
NEW JERSEY	$137	-	-	$137	-	-	$273	-	-	$414	-	-
NEW MEXICO	$131	-	-	$131	-	-	$189	-	-	$281	-	-
NEW YORK	$313	$189	$124	$313	$189	$124	$422	$278	$144	$602	$419	$183
N CAROLINA	$268	-	-	$268	-	-	$352	-	-	$442	-	-
N DAKOTA	$96	-	-	$193	-	-	$289	-	-	$437	-	-
OHIO	$298	-	-	$298	-	-	$393	-	-	$584	-	-
OKLAHOMA	$84	-	-	$167	-	-	$218	-	-	$349	-	-
OREGON	$151	-	-	$239	-	-	$303	-	-	$358	-	-
PENNSYLVANIA	$272	$220	$52	$272	$220	$52	$498	$348	$150	$592	$525	$67
RHODE ISLAND	$158	$128	$30	$270	$218	$52	$370	$299	$71	$520	$421	$99
S CAROLINA	$102	-	-	$102	-	-	$144	-	-	$229	-	-
S DAKOTA	$217	-	-	$217	-	-	$280	-	-	$361	-	-
TENNESSEE	$91	-	-	$91	-	-	$142	-	-	$217	-	-
TEXAS	$33	-	-	$89	-	-	$122	-	-	$201	-	-
UTAH	$330	-	-	$330	-	-	$443	-	-	$697	-	-
VERMONT	$311	-	-	$311	-	-	$441	-	-	$672	-	-
VIRGINIA	$214	$128	$86	$214	$128	$86	$287	$201	$86	$400	$314	$86
WASHINGTON	$442	-	-	$442	-	-	$560	-	-	$814	-	-
W VIRGINIA	$161	$72	$89	$161	$72	$89	$219	$130	$89	$332	$238	$94
WISCONSIN	$284	$275	$9	$284	$275	$9	$503	$488	$15	$706	$685	$21
WYOMING	$195	-	-	$195	-	-	$320	-	-	$390	-	-

* One Adult ** One Adult and Three Children
*** Data Not Reported or Not Available

Table 3.1.1(D)

AFDC STANDARDS FOR BASIC NEEDS

	PAYMENT STANDARD											
	One Child			One Adult			Family of Two			Family of Four		
	Highest	Lowest	Difference	Highest	Lowest	Difference	Highest	Lowest	Difference	Highest	Lowest	Difference
ALABAMA	$59	-	-	$59	-	-	$118	-	-	$148	-	-
ALASKA	$238	-	-	$359	-	-	$597	-	-	$751	-	-
ARKANSAS	$59	-	-	$59	-	-	$116	-	-	$164	-	-
CALIFORNIA	$248	-	-	$248	-	-	$408	-	-	$601	-	-
COLORADO	$98	-	-	$192	-	-	$252*	-	-	$387**	-	-
CONNECTICUT	$134	-	-	$134	-	-	$358	-	-	$517	-	-
DELAWARE	$141	-	-	$141	-	-	$197	-	-	$312	-	-
DIST COLUMBIA	$198	-	-	$198	-	-	$237	-	-	$366	-	-
FLORIDA	$127	$72	$55	$127	$72	$55	$172	$117	$55	$263	$187	$76
GEORGIA	$107	-	-	$107	-	-	$162	-	-	$229	-	-
HAWAII	$297	-	-	$297	-	-	$398	-	-	$546	-	-
IDAHO	$208	-	-	$208	-	-	$245	-	-	$306	-	-
ILLINOIS	$88	$66	$14	$198	$161	$37	$250	$205	$45	$368	$309	$59
INDIANA	$167	-	-	$167	-	-	$222	-	-	$327	-	-
IOWA	$154	-	-	$154	-	-	$292	-	-	$419	-	-
KANSAS	$216	-	-	$216	-	-	$288	-	-	$385	-	-
KENTUCKY	$133	-	-	$133	-	-	$162	-	-	$235	-	-
LOUISIANA	$72	-	-	$72	-	-	$138	-	-	$234	-	-
MAINE	$87	-	-	$152	-	-	$241	-	-	$400	-	-
MARYLAND	$131	-	-	$131	-	-	$238	-	-	$355	-	-
MASSACHUSETTS	$248	-	-	$248	-	-	$314	-	-	$445	-	-
MICHIGAN	$278	$228	$50	$278	$228	$50	$354	$304	$50	$492	$442	$50
MINNESOTA	$218	-	-	$158	-	-	$368	-	-	$520	-	-
MISSISSIPPI	$171	-	-	$171	-	-	$244	-	-	$327	-	-
MISSOURI	$121	-	-	$121	-	-	$209	-	-	$305	-	-
MONTANA	$212	-	-	$212	-	-	$279	-	-	$425	-	-
NEBRASKA	$218	-	-	$218	-	-	$288	-	-	$428	-	-
NEVADA	$44	-	-	$138	-	-	$183	-	-	$272	-	-
NEW HAMPSHIRE	$241	-	-	$241	-	-	$292	-	-	$392	-	-
NEW JERSEY	$137	-	-	$137	-	-	$273	-	-	$414	-	-
NEW MEXICO	$131	-	-	$131	-	-	$189	-	-	$281	-	-
NEW YORK	$313	$189	$124	$313	$189	$124	$422	$278	$144	$602	$419	$183
N CAROLINA	$134	-	-	$134	-	-	$176	-	-	$221	-	-
N DAKOTA	$96	-	-	$193	-	-	$289	-	-	$437	-	-
OHIO	$111	-	-	$111	-	-	$216	-	-	$327	-	-
OKLAHOMA	$84	-	-	$167	-	-	$218	-	-	$349	-	-
OREGON	$151	-	-	$239	-	-	$303	-	-	$358	-	-
PENNSYLVANIA	$181	$147	$34	$181	$147	$34	$273	$232	$41	$415	$367	$48
RHODE ISLAND	$158	$128	$30	$270	$218	$52	$378	$299	$71	$520	$421	$99
S CAROLINA	$75	-	-	$75	-	-	$106	-	-	$169	-	-
S DAKOTA	$217	-	-	$217	-	-	$288	-	-	$361	-	-
TENNESSEE	$65	-	-	$65	-	-	$101	-	-	$154	-	-
TEXAS	$23	-	-	$62	-	-	$85	-	-	$141	-	-
UTAH	$215	-	-	$215	-	-	$289	-	-	$455	-	-
VERMONT	$202	-	-	$202	-	-	$287	-	-	$437	-	-
VIRGINIA	$193	$115	$78	$193	$115	$78	$258	$181	$77	$360	$283	$77
WASHINGTON	$288	-	-	$288	-	-	$365	-	-	$531	-	-
W VIRGINIA	$242	$108	$134	$242	$108	$134	$329	$195	$134	$498	$357	$141
WISCONSIN	$241	$234	$7	$241	$234	$7	$428	$415	$13	$600	$582	$18
WYOMING	$195	-	-	$195	-	-	$320	-	-	$398	-	-

* One Adult ** One Adult and Three Children

*** Data Not Reported or Not Available

Table 3.1.1(E)

AFDC STANDARDS FOR BASIC NEEDS

	MAXIMUM PAYMENT											
	One Child			One Adult			Family of Two			Family of Four		
	Highest	Lowest	Difference	Highest	Lowest	Difference	Highest	Lowest	Difference	Highest	Lowest	Difference
ALABAMA	$59	-	-	$59	-	-	$118	-	-	$148	-	-
ALASKA	$238	-	-	$359	-	-	$597	-	-	$751	-	-
ARKANSAS	$59	-	-	$59	-	-	$116	-	-	$169	-	-
CALIFORNIA	$240	-	-	$240	-	-	$400	-	-	$601	-	-
COLORADO	$90	-	-	$192	-	-	$252*	-	-	$387**	-	-
CONNECTICUT	$134	-	-	$134	-	-	$358	-	-	$517	-	-
DELAWARE	$141	-	-	$141	-	-	$197	-	-	$312	-	-
DIST COLUMBIA	$190	-	-	$190	-	-	$237	-	-	$366	-	-
FLORIDA	$127	$72	$55	$127	$72	$55	$172	$117	$55	$263	$187	$76
GEORGIA	$107	-	-	$107	-	-	$162	-	-	$229	-	-
HAWAII	$297	-	-	$297	-	-	$390	-	-	$544	-	-
IDAHO	$200	-	-	$200	-	-	$245	-	-	$384	-	-
ILLINOIS	$80	$66	$14	$198	$161	$37	$250	$205	$45	$368	$309	$59
INDIANA	$98	-	-	$98	-	-	$195	-	-	$315	-	-
IOWA	$154	-	-	$154	-	-	$292	-	-	$419	-	-
KANSAS	$216	-	-	$216	-	-	$288	-	-	$385	-	-
KENTUCKY	$133	-	-	$133	-	-	$162	-	-	$235	-	-
LOUISIANA	$72	-	-	$72	-	-	$138	-	-	$234	-	-
MAINE	$87	-	-	$152	-	-	$241	-	-	$408	-	-
MARYLAND	$131	-	-	$131	-	-	$230	-	-	$355	-	-
MASSACHUSETTS	$248	-	-	$248	-	-	$314	-	-	$445	-	-
MICHIGAN	$278	$228	$50	$278	$228	$50	$354	$304	$50	$492	$442	$50
MINNESOTA	$218	-	-	$158	-	-	$368	-	-	$520	-	-
MISSISSIPPI	$60	-	-	$60	-	-	$96	-	-	$144	-	-
MISSOURI	$121	-	-	$121	-	-	$209	-	-	$305	-	-
MONTANA	$212	-	-	$212	-	-	$279	-	-	$425	-	-
NEBRASKA	$218	-	-	$218	-	-	$288	-	-	$428	-	-
NEVADA	$64	-	-	$138	-	-	$183	-	-	$272	-	-
NEW HAMPSHIRE	$241	-	-	$241	-	-	$292	-	-	$392	-	-
NEW JERSEY	$137	-	-	$137	-	-	$273	-	-	$414	-	-
NEW MEXICO	$131	-	-	$131	-	-	$189	-	-	$281	-	-
NEW YORK	$313	$189	$124	$313	$189	$124	$422	$278	$144	$602	$419	$183
N CAROLINA	$134	-	-	$134	-	-	$176	-	-	$221	-	-
N DAKOTA	$96	-	-	$193	-	-	$289	-	-	$437	-	-
OHIO	$111	-	-	$111	-	-	$216	-	-	$327	-	-
OKLAHOMA	$84	-	-	$167	-	-	$218	-	-	$349	-	-
OREGON	$151	-	-	$239	-	-	$303	-	-	$358	-	-
PENNSYLVANIA	$181	$147	$34	$181	$147	$34	$273	$232	$41	$415	$367	$48
RHODE ISLAND	$150	$128	$30	$270	$218	$52	$370	$299	$71	$520	$421	$99
S CAROLINA	$75	-	-	$75	-	-	$106	-	-	$169	-	-
S DAKOTA	$217	-	-	$217	-	-	$280	-	-	$361	-	-
TENNESSEE	$65	-	-	$65	-	-	$101	-	-	$154	-	-
TEXAS	$23	-	-	$62	-	-	$85	-	-	$140	-	-
UTAH	$215	-	-	$215	-	-	$289	-	-	$455	-	-
VERMONT	$202	-	-	$202	-	-	$287	-	-	$437	-	-
VIRGINIA	$193	$115	$78	$193	$115	$78	$250	$181	$77	$360	$283	$77
WASHINGTON	$288	-	-	$288	-	-	$365	-	-	$531	-	-
W VIRGINIA	$121	$54	$67	$121	$54	$67	$164	$98	$66	$249	$179	$70
WISCONSIN	$241	$234	$7	$241	$234	$7	$428	$415	$13	$600	$582	$18
WYOMING	$195	-	-	$195	-	-	$320	-	-	$390	-	-

* One Adult ** One Adult and three Children
*** Data Not Reported or Not Available

States choosing either the first or second option must provide Medicaid to aged, blind, and disabled individuals or couples who receive SSI (42 CFR 435.120). This includes individuals receiving SSI pending a final determination of blindness or disability; individuals receiving SSI under agreement to dispose of resources that exceed SSI resource limits; and, from January 1, 1981 until December 31, 1983, individuals considered to be receiving SSI under 1619(b) of the Social Security Act (blind or disabled individuals whose income equals or exceeds a specific SSI limit). Individuals entitled to benefits under Section 1622 of the Social Security Act are not considered individuals receiving SSI and therefore are not eligibile for Medicaid.

Table 3.1.2(A) displays the States that provide Medicaid to aged, blind, and disabled individuals or couples who receive SSI. Thirty-five States have chosen this option and those 36 States account for 85.7 percent of the total SSI cash recipients.

The 14 States choosing the third option (209(b) States) have more restrictive requirements for Medicaid than the SSI requirements (42 CFR 435.121). Four States are more restrictive in defining disability, ten States are more restrictive in setting financial requirements for income or resources, or both, three States are more restrictive with relative responsibility laws, and one State is more restrictive with transfer of property laws. The requirements may apply to the aged or the blind or the disabled or any combination. However, each requirement may be no more restrictive than that in effect under the State's Medicaid plan on January 1, 1972 and in general, no more liberal than that applied under SSI or an optional State supplement program. The 14 States selecting the 209(b) option account for 14.3 percent of the total number of SSI cash recipients.

A mandatory group of recipients is individuals who are ineligible for SSI or optional State supplements because of requirements that do not apply under Title XIX of the Social Security Act (42 CFR 435.122). These individuals who would be eligible for SSI or optional State supplements except for an eligibility requirement used in those programs that is prohibited under Title XIX, such as placing liens against a recipients's property, must be provided

Table 3.1.2(A)

MANDATORY MEDICAID ELIGIBILITY GROUPS: AGED, BLIND, AND DISABLED

STATE	All SSI Recipients			Individuals Who Meet More Restrictive Eligibility Criteria			Those Who Are Not Eligible For SSI/SSP Due to Rules That Do Not Apply Under Title XIX	Individuals Receiving Mandatory State Supplements	1973 "GRANDFATHERED" GROUPS: Individuals who in December 1973 were eligible for Medicaid and have continued to be eligible under such rules:				
	Aged	Blind	Disabled	Aged	Blind	Disabled			Essential Spouses			Institutionalized Individuals	Blind and Disabled
									Aged	Blind	Disabled		
ALABAMA	X	X	X	-	-	-	-	X	-	-	-	X	X
ALASKA	X	X	X	-	-	-	-	X	-	-	-	X	X
ARKANSAS	X	X	X	-	-	-	-	X	X	X	X	X	X
CALIFORNIA	X	X	X	-	-	-	-	-	-	-	-	X	X
COLORADO	X	X	X	-	-	-	-	X	-	X	X	X	X
CONNECTICUT	-	-	-	X	X	X	X	X	-	-	-	X	X
DELAWARE	X	X	X	-	-	-	-	X	-	-	-	X	X
DIST COLUMBIA	X	X	X	-	-	-	-	X	X	X	X	X	X
FLORIDA	X	X	X	-	-	-	-	X	-	-	-	X	X
GEORGIA	X	X	X	-	-	-	-	X	-	-	-	X	X
HAWAII	-	-	-	X	X	X	-	X	X	X	X	X	X
IDAHO	X	X	X	-	-	-	-	X	-	-	-	X	X
ILLINOIS	-	-	-	X	X	X	-	X	-	-	-	X	X
INDIANA	-	-	-	X	X	X	-	X	-	-	-	X	X
IOWA	X	X	X	-	-	-	-	X	X	X	X	X	X
KANSAS	X	X	X	-	-	-	-	X	X	X	X	X	X
KENTUCKY	X	X	X	-	-	-	-	X	X	X	X	X	X
LOUISIANA	X	X	X	-	-	-	-	-	X	X	X	X	X
MAINE	X	X	X	-	-	-	-	-	X	X	X	X	X
MARYLAND	X	X	X	-	-	-	-	-	X	X	X	X	X
MASSACHUSETTS	X	X	X	-	-	-	X	-	X	X	X	X	X
MICHIGAN	X	X	X	-	-	-	-	X	-	-	-	X	X
MINNESOTA	-	-	-	X	X	X	-	X	-	-	-	X	X
MISSISSIPPI	X	X	X	-	-	-	-	X	-	-	-	X	X
MISSOURI	-	-	-	X	X	X	-	X	-	-	-	X	X
MONTANA	X	X	X	-	-	-	X	-	X	X	X	X	X
NEBRASKA	-	-	-	X	X	X	-	X	-	-	-	X	X
NEVADA	X	X	X	-	-	-	-	-	-	-	-	X	X
NEW HAMPSHIRE	-	-	-	X	X	X	X	X	-	-	-	X	X
NEW JERSEY	X	X	X	-	-	-	-	X	X	X	X	X	X
NEW MEXICO	X	X	X	-	-	-	-	X	-	-	-	X	X
NEW YORK	X	X	X	-	-	-	-	X	X	X	X	X	X
N CAROLINA	-	-	-	X	X	X	-	X	X	X	X	X	X
N DAKOTA	-	-	-	X	X	X	X	X	X	X	X	X	X
OHIO	-	-	-	X	X	X	-	-	X	X	X	X	X
OKLAHOMA	-	-	-	X	X	X	-	X	X	X	X	X	X
OREGON	X	X	X	-	-	-	-	X	X	X	X	X	X
PENNSYLVANIA	X	X	X	-	-	-	-	X	X	X	X	X	X
RHODE ISLAND	X	X	X	-	-	-	-	X	X	X	X	X	X
S CAROLINA	X	X	X	-	-	-	-	-	X	X	X	X	X
S DAKOTA	X	X	X	-	-	-	-	X	-	-	-	X	X
TENNESSEE	X	X	X	-	-	-	-	X	-	-	-	X	X
TEXAS	X	X	X	-	-	-	-	-	-	-	-	X	X
UTAH	-	-	-	X	X	X	-	X	X	X	X	X	X
VERMONT	X	X	X	-	-	-	-	X	X	X	X	X	X
VIRGINIA	-	-	-	X	X	X	X	X	X	X	X	X	X
WASHINGTON	X	X	X	-	-	-	-	-	X	X	X	X	X
W VIRGINIA	X	X	X	-	-	-	-	-	X	X	X	X	X
WISCONSIN	X	X	X	-	-	-	X	-	X	X	X	X	X
WYOMING	X	X	X	-	-	-	-	X	X	X	X	X	X
TOTAL STATES	36	36	36	14	14	14	7	37	28	29	29	50	50
% RECIPIENTS FOR CATEGORY	85.7	85.7	85.7	14.3	14.3	14.3	6.9	57.7	45.4	46.4	46.4	100	100

Medicaid. Seven States provide Medicaid to this group of individuals. As seen on Table 3.1.2(A), the seven States account for 6.9 percent of the total SSI cash recipients.

When the Social Security Amendments of 1972 were enacted, States that had been making higher payments to individuals under the previous programs of cash assistance were required to pay the difference between the SSI benefit and the previous payment. These are known as mandatory State supplements and individuals receiving mandatory State supplements must be provided Medicaid (42 CFR 435.130). As shown on Table 3.1.2(A), 37 States pay mandatory State supplements. The 37 States that provide mandatory State supplements account for 57.5 percent of the total SSI cash recipients.

Whichever major option for coverage of the aged, blind, or disabled a State elects, all States are required to provide Medicaid to certain groups of individuals who were eligible for Medicaid in December 1973 under optional coverage provisions. These groups include essential spouses, institutionalized individuals, and blind and disabled individuals. They are displayed on Table 3.1.2(A) under 1973 "grandfathered" groups and are discussed individually below.

The State agency must provide Medicaid to any person who was eligible for Medicaid in December 1973 as an essential spouse of an aged, blind or disabled individual who was receiving cash assistance (42 CFR 435.131). An "essential spouse" is defined to be one who is living with the individual, whose needs were included in determining the amount of cash payment, and who is determined essential to the individual's well being. Medicaid must be continued if both the aged, blind, or disabled individual and the essential spouse continue to meet the conditions in effect as of December 1973. Twenty-eight States have an essential spouses grandfathered group for aged individuals, 29 States have an essential spouses grandfathered group for the blind, and 29 States have a group for the disabled. One of the States has essential spouses for two groups (Colorado - blind and disabled) while all other States that have essential spouses include the aged, blind, and disabled. In each case these States account for between 45.4 percent and 46.4 percent of the total SSI cash recipients.

A second 1973 "grandfathered" group is institutionalized individuals who were eligible in December 1973 (42 CFR 435.132). Individuals who were eligible for Medicaid in December 1973, or any part of that month, as inpatients of medical institutions or residents of ICFs that were participating in the Medicaid program must be provided Medicaid. The individual, for each month after December 1973, must continue to meet the 1973 eligibility requirements, remain institutionalized, and be determined by a review organization to need institutional care. Table 3.1.2(A) shows that all 50 States provide Medicaid for this group.

The third 1973 "grandfathered" group is the blind and disabled. Medicaid must be provided to individuals who meet all current requirements for Medicaid eligibility except the criteria for blindness or disability, were eligibile for Medicaid in December 1973, and for each consecutive month after December 1973 have continued to meet eligibility criteria used under the Medicaid plan in December 1973 (42 CFR 435.133). These individuals were "grandfathered" by all 50 States as seen on Table 3.1.2(A).

There are certain individuals that must be provided Medicaid because they are members of a 1972 pass-through group (42 CFR 435.134). These are individuals who would currently be eligibile for AFDC except that the increase in Old Age, Survivors and Disability Insurance (OASDI) under Title II of the Social Security Act raised their income over the limit allowed for SSI. The individuals must meet the following criteria:

- In August 1972, the individual was entitled to OASDI and
- He was receiving OAA, AB, APTD, or AABD or he would have been eligible for one of those programs except that he had not applied, or he would have been eligible for one of those programs if he were not in a medical institution or ICF; and
- He meets all current SSI requirements except for the requirement to file an application or would meet all current requirements if he were not in a medical institution or ICF.

Table 3.1.2(B) displays the 1972 "pass-through" groups. Few, if any, individuals from these 1972 pass-through groups should still be eligible. Twenty-four States cover individuals that would have been eligible for SSI if they had applied and the State Medicaid plan covered this optional group in

Table 3.1.2(B)

MANDATORY MEDICAID ELIGIBILITY GROUPS: AGED, BLIND, AND DISABLED

	1972 "PASS-THROUGH" GROUPS			1977 "PASS-THROUGH" GROUPS		
	Those ineligible for SSI/SSP due to a July 1972 increase in OASDI benefits and who, in August 1972, were:			Those who had received SSI/SSP and would now be eligible for such Payments But For Increases In OASDI Benefits Paid After April, 1977		
STATE	Those who were eligible But Had Not Applied	Institutionalized Individuals Medical Institutions	Not ICFs	Not Applicable In SSP Recipients	Not Applicable Due To More Restrictive State Requirements	State Deducts from Income the Amount of Increase That Caused Ineligibility
ALABAMA	-	X	-	-	-	-
ALASKA	X	X	-	-	-	-
ARKANSAS	-	-	-	-	-	-
CALIFORNIA	X	X	X	-	-	X
COLORADO	X	X	-	-	-	-
CONNECTICUT	X	X	X	-	-	-
DELAWARE	-	X	-	-	-	-
DIST COLUMBIA	X	X	-	-	-	-
FLORIDA	-	X	-	X	-	-
GEORGIA	-	X	-	X	-	-
HAWAII	-	-	-	-	-	X
IDAHO	X	X	-	-	-	-
ILLINOIS	-	-	-	-	-	X
INDIANA	-	-	-	-	-	X
IOWA	-	X	-	-	-	-
KANSAS	-	-	-	-	-	-
KENTUCKY	-	X	-	-	-	-
LOUISIANA	X	X	-	-	-	-
MAINE	-	-	-	-	-	-
MARYLAND	X	X	-	-	-	-
MASSACHUSETTS	X	X	-	-	-	-
MICHIGAN	X	-	-	-	-	-
MINNESOTA	X	X	-	-	-	X
MISSISSIPPI	-	X	-	X	-	-
MISSOURI	-	-	-	-	X	-
MONTANA	X	X	-	-	-	-
NEBRASKA	-	-	-	-	-	X
NEVADA	X	X	-	-	-	-
NEW HAMPSHIRE	-	X	X	-	-	X
NEW JERSEY	-	X	-	-	-	-
NEW MEXICO	-	X	-	X	-	-
NEW YORK	X	X	-	-	-	-
N CAROLINA	-	-	-	-	-	-
N DAKOTA	-	-	-	-	X	-
OHIO	X	X	-	-	X	-
OKLAHOMA	X	X	-	-	-	X
OREGON	X	X	-	-	-	-
PENNSYLVANIA	X	X	-	-	-	-
RHODE ISLAND	X	X	-	-	-	-
S CAROLINA	-	X	-	-	-	-
S DAKOTA	-	-	-	-	-	-
TENNESSEE	-	X	-	-	-	-
TEXAS	-	-	-	X	-	-
UTAH	X	X	-	X	X	-
VERMONT	X	X	-	-	-	-
VIRGINIA	X	X	-	-	-	X
WASHINGTON	X	X	-	-	-	-
W VIRGINIA	-	-	-	X	-	-
WISCONSIN	X	X	-	X	-	-
WYOMING	-	X	-	X	-	-
TOTAL STATES	24	36	3	9	4	9
% RECIPIENTS FOR CATEGORY	57.3	79.5	20.7	19.9	3.7	28.5

August 1972. These 24 States account for 57.3 percent of the total number of SSI cash recipients. Thirty-six States cover institutionalized individuals in medical institutions that would have been eligible for SSI if the State Medicaid plan covered this optional group. These 36 States account for more than 79 percent of the total SSI cash recipients. Of the 36 States, three provide Medicaid to institutionalized individuals in medical institutions and not to individuals in intermediate care facilities.

A second "pass-through" group is displayed on Table 3.1.2(B). This group includes individuals who have become ineligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977 and would still be eligible for SSI/SSP if that increase were deducted from income (42 CFR 435.135). This is a mandatory eligibility group; however, there are certain recipients/States where coverage is not extended. If the State does not extend Medicaid coverage to its SSP recipients, or if it does not make State supplementary payments, then the State is <u>not</u> required to cover recipients that would be members of the 1977 "pass-through" group. There are nine States, accounting for 19.9 percent of the total SSI cash recipients, that do not make State supplementary payments or do not provide Medicaid to these individuals.

If a State adopts more restrictive eligibility requirements (209(b) State), other conditions determine the coverage of the 1977 pass-through group. The conditions are as follows:

- The State applies more restrictive eligibility requirements that preclude the coverage of this group and 42 CFR 435.135 is not applicable; and

- The State applies more restrictive eligibility requirements and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

The first category is limited to four States - Missouri, North Dakota, Ohio, and Utah. The second category is composed of nine States; those nine States make up 28.5 percent of the total SSI cash recipients.

3.2 OPTIONAL ELIGIBILITY

States can elect to cover selected groups of individuals under Medicaid who are financially eligible for cash assistance but ineligible because of certain other requirements, or who do not wish to receive cash assistance. Individuals eligible under these optional coverage provisions are considered categorically needy and are eligible for the same services provided under Medicaid to mandatory eligible groups. Further, unless specified, a Medicaid agency that chooses to cover an optional group must provide Medicaid to all eligible individuals in that group. The optional eligibility requirements and groups are discussed below under Families with Dependent Children and Supplemental Security Income.

3.2.1 AFDC Optional Eligibility

A State may provide Medicaid to individuals who would be eligible for AFDC but are not receiving these benefits (42 CFR 435.210). As noted on Table 3.2.1(A), 25 States have elected to cover this optional group and those 25 States account for 65.2 percent of the total non-cash AFDC recipients.

The State may provide Medicaid to individuals who would be eligible if they were not in a Title XIX reimbursable medical institution or ICF (42 CFR 435.211). There are individuals who are ineligible because of the lower income standards used to determine eligibility for institutionalized individuals. Thirty-eight States cover such individuals and those 38 States account for 78.4 percent of the total non-cash AFDC recipients.

A third AFDC optional Medicaid group that a State may elect to cover is individuals who would be eligible for AFDC if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure (42 CFR 435.220). This option is appropriate only for those States that deduct work-related child care costs from income to determine the amount of AFDC. Sixteen States include this optional group in their State plan, accounting for 56.7 percent of the total non-cash AFDC recipients.

Table 3.2.1(A) displays a fourth AFDC optional eligibility group - individuals who would be eligible for AFDC if coverage under the State's AFDC plan included individuals whose coverage under Title IV-A is optional (42 CFR 435.223). For example, Medicaid may be provided to members of families with

Table 3.2.1(A)

OPTIONAL MEDICAID ELIGIBILITY GROUPS: FAMILIES WITH DEPENDENT CHILDREN

STATE	Eligible for But Not Receiving AFDC	Would Be Eligible If Not In An Institution	Would Be Eligible If Child Care Costs Were Paid From Earnings	Those Who Would Be Eligible For AFDC If Coverage Were as Broad as Allowed Under Title IV-A, such as: Families With Unemployed Parents	Other
ALABAMA	-	X	-	-	-
ALASKA	X	X	-	-	-
ARKANSAS	-	X	-	-	-
CALIFORNIA	X	X	X	-	-
COLORADO	-	X	X	-	-
CONNECTICUT	X	-	-	-	-
DELAWARE	X	X	-	-	-
DIST COLUMBIA	X	X	X	-	X
FLORIDA	-	X	-	-	-
GEORGIA	-	X	-	-	-
HAWAII	X	X	X	-	-
IDAHO	X	X	-	-	-
ILLINOIS	-	-	-	-	-
INDIANA	-	-	-	-	-
IOWA	-	X	-	X	-
KANSAS	-	-	-	-	-
KENTUCKY	-	-	-	X	-
LOUISIANA	-	X	-	-	-
MAINE	-	-	X	-	-
MARYLAND	X	X	-	-	-
MASSACHUSETTS	X	X	-	-	-
MICHIGAN	-	-	-	-	-
MINNESOTA	X	X	X	-	X
MISSISSIPPI	-	X	-	-	-
MISSOURI	-	-	X	-	X
MONTANA	X	X	X	-	-
NEBRASKA	-	-	-	-	-
NEVADA	-	X	-	-	-
NEW HAMPSHIRE	X	X	X	-	-
NEW JERSEY	X	X	-	-	-
NEW MEXICO	-	X	-	-	-
NEW YORK	X	X	X	-	-
N CAROLINA	X	-	-	-	-
N DAKOTA	-	-	-	-	-
OHIO	-	X	-	-	-
OKLAHOMA	X	X	X	-	-
OREGON	X	X	-	-	-
PENNSYLVANIA	X	X	X	-	-
RHODE ISLAND	X	X	X	-	-
S CAROLINA	-	X	-	-	-
S DAKOTA	-	X	-	-	-
TENNESSEE	-	X	-	-	-
TEXAS	-	X	-	-	-
UTAH	X	X	X	-	-
VERMONT	X	X	X	-	-
VIRGINIA	X	X	-	-	-
WASHINGTON	X	X	-	-	-
W VIRGINIA	X	-	-	-	-
WISCONSIN	X	X	X	-	X
WYOMING	-	X	-	-	-
TOTAL STATES	25	38	16	2	4
% RECIPIENTS FOR CATEGORY	65.2	78.4	56.7	5.0	5.6

an unemployed parent even though AFDC is not available to them under the State's AFDC plan. Two States provide Medicaid to families with unemployed parents under this option. Those two States account for 5.0 percent of the total non-cash AFDC recipients. The State agency may also provide Medicaid to other individuals who would be eligible for AFDC if the State's AFDC plan did not contain eligibility requirements more restrictive, or in addition to, those required under Title IV-A. Four States include such individuals in their Medicaid State plan, accounting for 5.6 percent of the total non-cash AFDC recipients. D.C. did not note to which group "other" referred. Minnesota, Missouri, and Wisconsin reported that "other" referred to pregnant women with no other eligible children with Minnesota restricting this to the last trimester.

A final group of AFDC optional recipients includes individuals under age 21 who would be eligible for AFDC but do not qualify as dependent children (42 CFR 435.222). States can elect to either cover all such children including the unborn, all such excluding the unborn, or any number of reasonable classifications of such children. These categories of recipients are displayed on Table 3.2.1(B) with eight examples of reasonable classifications and one catchall category listed. The State may provide Medicaid to individuals under age 21 or under age 20, 19, or 18.

Eleven States include all reasonable classifications of individuals, including the unborn, under age 21 (20, 19, 18) who do not qualify as dependent children. Those 11 States account for 46.3 percent of the total non-cash AFDC recipients. Thirteen States include all reasonable classifications of individuals under age 21 (20, 19, 18) who do not qualify as dependent children. However, they do not include unborn children. The 13 States account for 21.1 percent of the total non-cash AFDC recipients.

The remaining 24 States cover from none (Ohio) to up to eight (Colorado and Washington) of the nine reasonable classifications of individuals under age 21 who do not qualify as dependent children. Unborn children are covered as a "reasonable classification" in six States (Delaware, Hawaii, Nebraska, Rhode Island, Tennessee, and Wyoming) which account for 2.5 percent of the total AFDC non-cash recipients.

Table 3.2.1(B)

OPTIONAL MEDICAID ELIGIBILITY GROUPS: FAMILIES WITH DEPENDENT CHILDREN
INDIVIDUALS UNDER AGE 21 WHO DO NOT QUALIFY AS DEPENDENT CHILDREN

	ALL SUCH CHILDREN		REASONABLE CLASSIFICATIONS OF SUCH CHILDREN								
				Those for Whom Public Agencies Are Assuming Some Financial Responsibility and Who are in:			Individuals Adoptions Subsidized by	Institutionalized Individuals:		Those in Psychiatric	
STATE	Including the Unborn	Excluding the Unborn	Unborn Children	Foster Homes	Private Institutions	Those Placed by Private, Nonprofit Agencies	Public Agency	In ICFs	Also, those in ICF-MRs	Facilities or Programs	Other Defined Groups
ALABAMA	18	-	-	-	-	-	-	-	-	-	-
ALASKA	21	-	-	-	-	-	-	-	-	-	-
ARKANSAS	-	18	-	21	-	-	-	-	-	-	-
CALIFORNIA	21	-	-	-	-	-	-	-	-	-	-
COLORADO	-	-	-	21	21	21	21	21	21	21	21
CONNECTICUT	21	-	-	-	-	-	-	-	-	-	-
DELAWARE	-	-	21	18	18	18	-	21	21	-	21
DIST COLUMBIA	21	-	-	-	-	-	-	-	-	-	-
FLORIDA	-	-	-	21	21	21	-	-	-	-	21
GEORGIA	-	-	-	18	18	-	-	-	-	-	18
HAWAII	-	-	19	19	19	-	-	19	19	-	19
IDAHO	-	18*	-	-	-	-	-	-	-	-	-
ILLINOIS	-	-	-	-	-	-	-	-	-	-	21
INDIANA	-	21	-	18	18	18	18	-	-	-	-
IOWA	21	-	-	-	-	-	-	-	-	-	-
KANSAS	-	-	-	21	21	-	21	21	21	21	21
KENTUCKY	-	-	-	19	19	19	19	-	-	19	19
LOUISIANA	-	-	-	21	21	-	-	21	21	21	-
MAINE	-	-	-	21	21	21	-	-	-	-	-
MARYLAND	21	-	-	-	-	-	-	-	-	-	-
MASSACHUSETTS	-	21	-	-	-	-	-	-	-	-	-
MICHIGAN	-	21	-	-	-	-	-	-	-	-	-
MINNESOTA	-	21	-	-	-	-	-	-	-	-	-
MISSISSIPPI	-	-	-	18	18	-	18	-	-	-	-
MISSOURI	-	-	-	21	21	-	21	21	21	21	-
MONTANA	-	21	-	-	-	-	-	-	-	-	-
NEBRASKA	-	-	21	21	21	21	-	-	-	21	18
NEVADA	-	19	-	-	-	-	-	-	-	-	-
NEW HAMPSHIRE	-	-	-	18	18	-	18	-	-	-	-
NEW JERSEY	21	-	-	-	-	-	-	-	-	-	-
NEW MEXICO	-	-	-	21	21	-	-	-	-	-	-
NEW YORK	21	-	-	-	-	-	-	-	-	-	-
N CAROLINA	-	-	-	19	19	-	-	19	19	19	19
N DAKOTA	-	21	-	-	-	-	-	-	-	-	-
OHIO	-	-	-	-	-	-	-	-	-	-	-
OKLAHOMA	-	21	-	-	-	-	-	-	-	-	-
OREGON	-	-	-	21	21	-	21	21	21	21	21
PENNSYLVANIA	-	21	-	-	-	-	-	-	-	-	-
RHODE ISLAND	-	-	19	19	-	19	19	19	19	-	-
S CAROLINA	-	-	-	21	21	-	-	-	-	-	-
S DAKOTA	-	-	-	-	-	-	21	21	21	-	21
TENNESSEE	-	-	21	21	21	-	21	-	-	21	21
TEXAS	-	19	-	-	-	-	-	-	-	-	-
UTAH	18	-	-	-	-	-	-	-	-	-	-
VERMONT	-	21	-	-	-	-	-	-	-	-	-
VIRGINIA	-	-	-	21	21	-	21	21	21	-	-
WASHINGTON	-	-	-	21	21	21	21	21	21	21	18
W VIRGINIA	-	-	-	18	-	-	18	18	18	-	-
WISCONSIN	18	-	-	19	-	-	-	-	-	-	-
WYOMING	-	-	21	-	-	-	-	-	-	-	-
TOTAL STATES	11	13	6	25	21	9	14	13	13	10	14
% RECIPIENTS FOR CATEGORY	46.3	21.1	2.5	31.1	25.7	10.8	14.8	11.2	11.2	13.4	33.8

* Under Age 19 if Individual is in School

If a public agency assumes full or partial financial responsibility for individuals in foster homes or private institutions, it may provide Medicaid coverage to those individuals. Twenty-five States provide Medicaid coverage to individuals in foster homes for whom a public agency is assuming full or partial financial responsibility. Twenty-one States provide Medicaid coverage to individuals in private institutions for whom a public agency is assuming full or partial financial responsibility. In addition, if the State covers individuals supported by the public, it may cover individuals of the same age placed in foster homes or private institutions by private non-profit agencies. Nine States provide Medicaid coverage for such individuals.

Individuals in adoptions subsidized in full or in part by a public agency may be covered as a reasonable classification. Fourteen States have chosen to cover this group. Individuals in ICFs, if ICFs are included in the State plan, can be covered as a reasonable classification. Thirteen States have elected to cover institutionalized individuals in ICFs. If the State covers these individuals, it may also provide Medicaid to individuals in ICF-MRs and all 13 of the States have chosen to do so. If inpatient psychiatric services for individuals under age 21 are provided under the plan, then individuals under age 21 receiving active treatment as inpatients in psychiatric facilities or programs can be included as a reasonable classification. Ten States have elected to cover this reasonable classification. Additionally, other defined groups may be included in the State plan. Groups such as children (only) in families with unemployed parents and children in private child caring institutions have been defined and extended Medicaid coverage. Fourteen States have elected to include at least one "other defined group" as a reasonable classification.

Note that in four States the age of the recipients varies by eligiblity category. Idaho provides services to all reasonable classifications, excluding the unborn, of individuals under age 18 with the exception that if an individual is under age 19 and is in school services will be provided. Two States (Arkansas - age 18 excluding the unborn; Wisconsin - age 18 including the unborn) have elected to cover certain reasonable classifications of individuals who are older (Arkansas - age 21; Wisconsin - age 19). In Indiana, all such individuals, excluding the unborn, under age 21 are covered.

However, certain reasonable classifications of individuals are covered only until they reach age 18. Those individuals had been living in foster homes or private institutions or were placed by private nonprofit agencies or were adoptions subsidized by public agencies and when they moved from those living arrangements the individuals were no longer covered.

3.2.2 SSI Optional Eligibility

A State may provide Medicaid to individuals who would be eligible for SSI or an optional State supplement but who are not receiving these benefits (42 CFR 435.210). Twenty-four States have elected to cover this optional group and those 24 States account for 41.5 percent of the total SSI non-cash recipients as seen in Table 3.2.2(A).

Some States pay only an optional State supplement to individuals. That supplement program must be:

- Based on need and paid regularly in cash;
- Equal to the difference between the individual's countable income and the income standard used to determine eligibility for supplement; and
- Available to all individuals in the State.

Individuals, in one or more of the following classifications, who receive only an optional State supplement and who would be eligible for SSI except for the level of their income may be provided Medicaid:

- All aged individuals;
- All blind individuals;
- All disabled individuals;
- Only aged individuals in domiciliary facilities or other group living arrangement as defined under SSI;
- Only blind individuals in domiciliary facilities or other group living arrangment as defined under SSI;
- Only disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI;

Table 3.2.2(A)

OPTIONAL MEDICAID ELIGIBILITY GROUPS: AGED, BLIND, AND DISABLED

STATE	Those eligible for but not receiving SSI/SSP	INDIVIDUALS WHO RECEIVE SUPPLEMENTARY PAYMENTS: All Aged	All Blind	All Disabled	Only those in Group Living Arrangements: Aged	Blind	Disabled	Those receiving Federally Administered State Supplement: Under 42 CFR §435.230	Under 20 CFR §416.2020(d)	Supplement Varies by Political Subdivision
ALABAMA	-	X	X	X	-	-	-	-	-	-
ALASKA	X	X	X	X	-	-	-	-	-	-
ARKANSAS	-	-	-	-	-	-	-	-	-	-
CALIFORNIA	-	X	X	X	-	-	-	X	X	-
COLORADO	-	X	-	-	-	-	-	-	-	-
CONNECTICUT	X	X	X	X	-	-	-	-	-	-
DELAWARE	X	-	-	-	-	-	-	X	-	-
DIST COLUMBIA	X	-	-	-	-	-	-	-	-	-
FLORIDA	-	-	-	-	-	-	-	-	-	-
GEORGIA	-	-	-	-	-	-	-	-	-	-
HAWAII	X	X	X	X	-	-	-	X	-	-
IDAHO	X	X	X	X	-	-	-	-	-	-
ILLINOIS	-	X	X	X	-	-	-	-	-	X
INDIANA	-	-	-	-	X	X	X	-	-	-
IOWA	-	-	X	-	X	-	X	X	-	-
KANSAS	-	-	-	-	-	-	-	-	-	-
KENTUCKY	-	-	-	-	X	X	X	-	-	-
LOUISIANA	-	-	-	-	-	-	-	-	-	-
MAINE	-	-	-	-	X	X	X	-	-	-
MARYLAND	X	-	-	-	X	X	X	-	-	-
MASSACHUSETTS	X	X	X	X	-	-	-	-	-	-
MICHIGAN	-	X	X	-	-	-	X	X	X	-
MINNESOTA	-	X	X	X	-	-	-	-	-	X
MISSISSIPPI	-	-	-	-	-	-	-	-	-	-
MISSOURI	-	-	X	-	X	-	X	-	-	-
MONTANA	X	X	X	X	-	-	-	X	-	-
NEBRASKA	-	X	X	X	-	-	-	-	-	-
NEVADA	-	X	X	-	-	-	-	-	-	-
NEW HAMPSHIRE	X	X	X	X	-	-	-	-	-	-
NEW JERSEY	X	X	X	X	-	-	-	X	-	-
NEW MEXICO	-	-	-	-	-	-	-	-	-	-
NEW YORK	X	X	X	X	-	-	-	-	-	X
N CAROLINA	X	-	-	-	X	X	X	-	-	-
N DAKOTA	X	-	-	-	-	-	-	-	-	-
OHIO	-	-	-	-	X	X	X	-	-	-
OKLAHOMA	X	X	X	X	-	-	-	-	-	-
OREGON	X	X	X	X	-	-	-	-	-	-
PENNSYLVANIA	X	X	X	X	-	-	-	X	X	-
RHODE ISLAND	X	X	X	X	-	-	-	X	X	-
S CAROLINA	-	-	-	-	X	X	X	-	-	-
S DAKOTA	-	-	-	-	X	X	X	-	-	-
TENNESSEE	-	-	-	-	-	-	-	-	-	-
TEXAS	-	-	-	-	-	-	-	-	-	-
UTAH	X	-	-	-	-	-	-	-	-	-
VERMONT	X	X	X	X	-	-	-	-	-	X
VIRGINIA	X	-	-	-	X	X	X	-	-	-
WASHINGTON	X	X	X	X	-	-	-	X	-	X
W VIRGINIA	X	-	-	-	-	-	-	-	-	-
WISCONSIN	X	X	X	X	-	-	-	-	-	-
WYOMING	-	-	-	-	-	-	-	-	-	-
TOTAL STATES	24	24	25	21	11	9	12	10	6	5
% RECIPIENTS FOR CATEGORY	41.5	63.9	67.6	57.9	19.4	14.9	24.5	33.2	26.0	23.9

- Individuals receiving a Federally administered optional State supplement; and

- Individuals in additional classifications specified by the Secretary for Federally administered supplementary payments under 20 CFR 416.2020(d).

Table 3.2.2(A) displays the States that cover each of the above eight optional groups. All aged receiving only State supplement payments (SSP) are covered by 24 States with those States accounting for 63.9 percent of the total SSI non-cash recipients. Twenty-five States cover all blind, accounting for 67.6 percent of the total SSI non-cash recipients, and 21 States cover all disabled, accounting for 57.9 percent of the total SSI non-cash recipients.

Nine States (Indiana, Kentucky, Maine, Maryland, North Carolina, Ohio, South Carolina, South Dakota, and Virginia) cover aged, blind, and disabled living in group living arrangements. Iowa and Missouri cover the aged and disabled and Michigan covers the disabled in group living arrangements. Group living arrangements are defined by the SSI program to be residence in domiciliary or congregate care facilities. Eleven States cover the blind in group living arrangements and account for 19.4 percent of the total SSI non-cash recipients. Nine States cover the aged in group living arrangements and account for 14.9 percent of the total SSI non-cash recipients. Twelve States cover the disabled in group living arrangements and account for 24.5 percent of the total SSI non-cash recipients. Ten States provide Medicaid coverage to individuals receiving a Federally administered optional State supplement, accounting for 33.2 percent of the total SSI non-cash recipients. Four States, California, Michigan, Pennsylvania, and Rhode Island, provide Medicaid to individuals in additional classifications specified by the Secretary for Federally administered supplementary payments and those States account for 26.0 percent of the total SSI non-cash recipients. The Federally administered State supplements vary by political subdivision in five States (Illinois, Minnesota, New York, Vermont, and Washington). These five States account for 23.9 percent of the total SSI non-cash recipients.

Special categories of institutionalized individuals may also be included as optional groups by a State agency. A State may provide Medicaid to individuals in Title XIX reimbursable medical institutions and intermediate care facilities who are ineligible for SSI/SSP because of lower income standards

used under these programs to determine eligibility for institutionalized individuals. Those individuals would be eligible for SSI/SSP if they were not institutionalized (42 CFR 435.211). If the agency provides Medicaid to these individuals, it may also elect to cover aged, blind, and disabled individuals in institutions who have income below a level specified in the plan (42 CFR 435.231). Thirty-five States, accounting for 55.1 percent of the total SSI non-cash recipients, cover individuals ineligible for SSI/SSP due to institutional status. Twenty-six States cover individuals in institutions who are eligible under a special income dollar level. The specific dollar level of each State is listed on Table 3.2.2(B) and ranges from $532 in Delaware to $853 in 17 States yielding a simple average of $799.

One group of individuals can be covered as an SSI optional eligibility group given that a State has applied for and been granted a waiver under Section 2176 of the Omnibus Reconciliation Act. If a State provides Medicaid to individuals in institutions who are eligible under a special income level, it may also cover aged, blind, and disabled individuals in the community who would be eligible for Medicaid if institutionalized. As of March 31, 1983, 27 States had applied for and had been granted a waiver under Section 2176 for home and community-based care thus making this group of individuals eligible to receive Medicaid.

As a result of the TEFRA 1982 (PL 97-248) provisions, optional Medicaid coverage was extended to certain disabled children, age 18 or under, living at home who would be eligible if in a medical institution. Eleven States (AL, CA, CO, GA, ID, KY, MS, NV, RI, WI, and WY) have chosen to extend coverage to these individuals. Those eleven States account for 24.7 percent of the total SSI non-cash recipients.

3.2.3 State Supplementation Programs for the Aged, Blind, and Disabled

The SSI program became effective January 1, 1974, and replaced the previous programs for the aged, blind, and disabled in all States. The new title (Title XVI) established nationwide eligibility standards and requirements and expanded the definition of disability to include individuals under age 18. It also provided for State supplements to the Federal SSI benefit.

Table 3.2.2(B)

OPTIONAL MEDICAID ELIGIBILITY GROUPS: AGED, BLIND AND DISABLED

STATE	INSTITUTIONALIZED INDIVIDUALS: Individuals ineligible for SSI/SSP due to institutional status	INSTITUTIONALIZED INDIVIDUALS: Those in institutions who are eligible under a special income level (dollar amount)	Individuals recieving home and community-based servs under 2176 waiver	Certain Disabled Children Age 18 or under at home who would be eligible if in a medical institution
ALABAMA	X	6853	X	X
ALASKA	X	6853	-	-
ARKANSAS	X	0853	-	-
CALIFORNIA	-	--	X	X
COLORADO	X	0853	X	X
CONNECTICUT	-	--	-	-
DELAWARE	X	0532	-	-
DIST COLUMBIA	X	NN	-	-
FLORIDA	X	0786	X	-
GEORGIA	-	--	X	X
HAWAII	X	NN	-	-
IDAHO	X	0610	-	X
ILLINOIS	-	--	X	-
INDIANA	-	--	-	-
IOWA	X	0853	X	-
KANSAS	-	--	X	-
KENTUCKY	-	--	X	X
LOUISIANA	X	NN	X	-
MAINE	X	0853	-	-
MARYLAND	-	--	X	-
MASSACHUSETTS	X	0714	X	-
MICHIGAN	-	--	-	-
MINNESOTA	X	NN	X	-
MISSISSIPPI	X	0853	-	X
MISSOURI	-	--	X	-
MONTANA	X	NN	X	-
NEBRASKA	-	--	-	-
NEVADA	X	0714	X	X
NEW HAMPSHIRE	X	0767	-	-
NEW JERSEY	X	0853	X	-
NEW MEXICO	X	0778	-	-
NEW YORK	X	0794	X	-
N CAROLINA	-	--	X	-
N DAKOTA	-	--	-	-
OHIO	-	--	-	-
OKLAHOMA	X	NN	-	-
OREGON	X	0853	X	-
PENNSYLVANIA	X	0853	-	-
RHODE ISLAND	X	6853	X	X
S CAROLINA	X	0853	X	-
S DAKOTA	X	0853	X	-
TENNESSEE	X	NN	-	-
TEXAS	X	6568	-	-
UTAH	X	NN	-	-
VERMONT	-	--	X	-
VIRGINIA	X	0853	X	-
WASHINGTON	X	6853	X	-
W VIRGINIA	X	6853	X	-
WISCONSIN	X	6853	-	X
WYOMING	X	NN	-	X
TOTAL STATES	35	26	27	11
% RECIPIENTS FOR CATEGORY	55.1	55.6	65.0	24.7

NN Indicates Data Not Reported

States that had been making higher payments to individuals under the previous program of cash assistance were required to pay the difference between the SSI benefit and the previous payment (42 CFR 435.1). There are 37 States, accounting for 60.5 percent of the total number of Medicaid recipients, that are required to pay mandatory State supplements (see Table 3.2.3(A)).

States may also pay optional State supplements for "basic" needs and/or for "special" needs. In general, "basic" needs are defined to be recurring monthly expenses, primarily food, shelter, clothing, utilities, and daily living necessities. "Special" needs refer to emergency or special conditions requiring additional assistance not provided through SSI or optional SSP for basic needs. Such items as disaster benefits, burial expenses, additional subsidies for institutional care, and moving expenses are in this category. These optional State supplements may be paid to all aged, blind, and disabled SSI or only to reasonable classifications (e.g., aged). Thirty States, accounting for 71.9 percent of the total number of Medicaid recipients, paid optional State supplements for basic needs to at least some SSI/SSP recipients. Nineteen States, accounting for 43.0 percent of the total number of Medicaid recipients, paid optional State supplements for special needs to at least some SSI/SSP recipients.

Table 3.2.3(B) displays the total monthly combined Federal/State payment levels to recipients with no countable income and no special needs. The Federal payment level in March 1983 was $294.30 for individuals and $441.40 for an eligible couple living independently with no countable income or resources. The State payment level for mandatory payments varies as to the December 1973 income level of the aged, blind, and disabled. The State optional payment may vary by:

- Categorical group (aged, blind, disabled);
- Geographic variations; and
- Living arrangements.

The highest payment levels were for California and Alaska while 12 States report the lowest payment levels. Those 12 States provide only Federal payments. The exhibit below displays the range and the absolute difference of the total combined Federal/State payment levels.

Table 3.2.3(A)

STATE SUPPLEMENTATION PROGRAMS FOR THE AGED, BLIND, AND DISABLED

STATE	Mandatory State Supplements	Optional State Supplements For Basic Needs	Optional State Supplements For Special Needs
ALABAMA	X	X	-
ALASKA	X	X	-
ARKANSAS	X	-	-
CALIFORNIA	-	X	X
COLORADO	X	-	-
CONNECTICUT	X	X	X
DELAWARE	X	X	-
DIST COLUMBIA	X	X	X
FLORIDA	X	X	-
GEORGIA	X	-	-
HAWAII	X	X	X
IDAHO	X	X	X
ILLINOIS	X	X	-
INDIANA	X	X	-
IOWA	X	-	X
KANSAS	X	-	-
KENTUCKY	X	-	X
LOUISIANA	-	-	-
MAINE	-	X	-
MARYLAND	-	-	X
MASSACHUSETTS	-	X	-
MICHIGAN	X	X	X
MINNESOTA	X	X	X
MISSISSIPPI	X	-	-
MISSOURI	X	X	-
MONTANA	-	-	-
NEBRASKA	X	X	X
NEVADA	-	X	X
NEW HAMPSHIRE	X	X	-
NEW JERSEY	X	X	-
NEW MEXICO	X	-	X
NEW YORK	X	X	-
N CAROLINA	X	-	X
N DAKOTA	X	-	-
OHIO	-	-	X
OKLAHOMA	X	X	-
OREGON	X	X	X
PENNSYLVANIA	X	X	-
RHODE ISLAND	X	X	-
S CAROLINA	-	-	X
S DAKOTA	X	X	X
TENNESSEE	X	-	-
TEXAS	-	-	-
UTAH	X	-	-
VERMONT	X	X	-
VIRGINIA	X	-	X
WASHINGTON	-	X	-
W VIRGINIA	-	-	-
WISCONSIN	-	X	-
WYOMING	X	X	-
TOTAL STATES	37	30	19
% RECIPIENTS FOR CATEGORY	60.5	71.9	43.0

* Indicates Data Not Reported

Table 3.2.3(B)

STATE SUPPLEMENTATION PROGRAMS FOR THE AGED, BLIND, AND DISABLED

Total Monthly Combined Federal/State Payment Levels To Recipients With No Countable Income And No Special Needs

	Individual Living Independently			Couple Living Independently		
STATE	Aged	Blind	Disabled	Aged	Blind	Disabled
ALABAMA	$344	$344	$344	$546	$546	$546
ALASKA	$546	$546	$546	$802	$802	$802
ARKANSAS	$294	$294	$294	$441	$441	$441
CALIFORNIA	$794	$794	$794	$1,191	$1,191	$1,191
COLORADO	$352	$298	$298	$682	$596	$596
CONNECTICUT	***	***	***	***	***	***
DELAWARE	$304	$304	$304	$456	$456	$456
DIST COLUMBIA	$319	$319	$319	$486	$486	$486
FLORIDA *	$383	$383	$383	$618	$618	$618
GEORGIA	$347	$303	$347	$464	$441	$441
HAWAII	$294	$294	$294	$441	$441	$441
IDAHO	$327	$327	$327	$440	$440	$440
ILLINOIS	****	****	****	****	****	****
INDIANA	$304	$304	$304	$456	$456	$456
IOWA	$294	$306	$294	$441	$470**	$441
KANSAS	$304	$304	$304	$456	$456	$456
KENTUCKY	$294	$294	$294	$441	$441	$441
LOUISIANA	$304	$304	$304	$456	$456	$456
MAINE	$294	$294	$294	$441	$441	$441
MARYLAND	$294	$294	$294	$441	$441	$441
MASSACHUSETTS	$422	$442	$407	$320	$442	$310
MICHIGAN	$318	$318	$318	$477	$477	$477
MINNESOTA	$339	$339	$399	$521	$521	$521
MISSISSIPPI	$294	$294	$294	$441	$441	$441
MISSOURI	$304	$304	$304	$456	$456	$456
MONTANA	$304	$304	$304	$456	$456	$456
NEBRASKA	$369	$369	$369	$552	$552	$552
NEVADA	$341	$414	$304	$536	$828	$446
NEW HAMPSHIRE	$308	$308	$308	$442	$442	$442
NEW JERSEY	$311	$311	$311	$448	$448	$448
NEW MEXICO	$295	$295	$295	$442	$442	$442
NEW YORK	$348	$348	$348	$506	$506	$506
N CAROLINA	$294	$294	$294	$441	$441	$441
N DAKOTA	$294	$294	$294	$441	$441	$441
OHIO *	$450	$450	$450	$900	$900	$900
OKLAHOMA	$363	$363	$363	$584	$584	$584
OREGON	$296	$321	$296	$441	$467	$441
PENNSYLVANIA	$317	$317	$317	$475	$475	$475
RHODE ISLAND	$335	$335	$335	$521	$521	$521
S CAROLINA *	$400	$400	$400	$800	$800	$800

Table 3.2.3(B) (Con't)

STATE SUPPLEMENTATION PROGRAMS FOR THE AGED, BLIND, AND DISABLED

Total Monthly Combined Federal/State Payment Levels To Recipients With No Countable Income And No Special Needs

STATE	Individual Living Independently			Couple Living Independently		
	Aged	Blind	Disabled	Aged	Blind	Disabled
S DAKOTA	$319	$319	$319	$471	$471	$471
TENNESSEE	$304	$304	$304	$456	$456	$456
TEXAS	$294	$294	$294	$441	$441	$441
UTAH	$314	$314	$314	$481	$481	$481
VERMONT	$332	$332	$332	$514	$514	$514
VIRGINIA	$294	$294	$294	$441	$441	$441
WASHINGTON	$361	$361	$361	$499	$499	$499
W VIRGINIA	$294	$294	$294	$441	$441	$441
WISCONSIN	$404	$404	$404	$617	$617	$617
WYOMING	$324	$324	$324	$496	$496	$496
SIMPLE AVERAGE	$340	$340	$339	$515	$523	$511

* Residential Care Facility
** Both Blind For Couple Living Independently - Blind
*** Data Not Reported
**** Dependent On Need And Income

NOTE: Florida, Georgia, and Ohio reported variable payment levels. The highest level is listed in the table.

	Total Combined Federal/State Payment Levels					
	Individual Living Independently			Couple Living Independently		
	Aged	Blind	Disabled	Aged	Blind	Disabled
High	$794 (CA)	$794 (CA)	$794 (CA)	$1,191 (CA)	$1,191 (CA)	$1,191 (CA)
Low	$294 (*)	$294 (*)	$294 (*)	$441 (*)	$441 (*)	$441 (*)
Difference	$500	$500	$500	$750	$750	$750
Average All States	$340	$340	$339	$515	$523	$511

(*) AR, HI, IO, KY, ME, MD, MS, NC, ND, TX, VA, WV.

The simple average monthly combined Federal/State payment level for each of the groups shown lie much closer to the "low" than to the "high."

3.3 MEDICALLY NEEDY

The medically needy program is a very important option that can be exercised under the Medicaid program (42 CFR 435.300). The general intent of the medically needy option is to accommodate individuals who meet all criteria for categorically needy assistance with the exception of income and who have incurred relatively large medical bills. Since 1969, the medically needy income standards have been limited to 133 1/3 percent of the maximum assistance payments for similarly sized families under AFDC in a given State. That is, families whose monthly incomes are between the AFDC payment standard and 133 1/3 percent of that standard are eligible for assistance as medically needy.

Through the spend-down provision, individuals or families can become eligible for Medicaid under the medically needy program if they have income above the 133 1/3 percent level but have high medical expenses which reduce income below the medically needy maximum. The 1981 Amendments gave the States the flexibility in determining what categorical groups, e.g., the aged, or the blind, or the disabled, would be eligible for Medicaid as medically needy. The States may now elect to cover some groups and not others.

Table 3.3.1 indicates the 30 States which have medically needy programs, the spend-down time period (months), and the allowable resources and protected income levels for the medically needy by number of family members by State. The spend-down time period ranges from one month in California, North Dakota, Hawaii, and Utah to six months in 19 States. Thus, the average spend-down time period for all medically needy States is approximately five months. Note that five States have variable spend down time periods that are between one and six months generally. These spend down time periods are at applicants' option in one State, one month for institutionalized in one State, and variable to coincide with eligibility review dates in other States.

There are three general Federal requirements for the medically needy resource standards. The standards must be: based on family size, uniform for all individuals in a group, and reasonable. The allowable resource standards are highest in North Dakota with $8000, $9500, and $9550 for one, two, and four persons respectively and lowest in Maine with $1500, $2250, and $2250 for one, two, and four persons respectively. The average allowable resources in medically needy States are $2030, $2963, and $3236 for one, two, and four persons respectively.

The State plan must specify the income standards for each covered medically needy group and those standards must be based on family size and uniform for all individuals in a covered group, in addition to the FFP requirements of not exceeding 133 1/3 percent of the AFDC payment. The range, difference, and average protected income level for one, two, and four persons is displayed in the exhibit below:

Monthly Protected Income Level

	One Person	Two Persons	Four Persons
High	$ 384 (Wisconsin)	$ 544 (California)	$ 801 (California)
Low	$ 117 (Tennessee)	$ 135 (Tennessee)	$ 205 (Tennessee)
Difference	$ 267	$ 409	$ 596
Average All States	$ 275	$ 356	$ 461

TABLE 3.3.1

MEDICALLY NEEDY: FINANCIAL CRITERIA

STATE	PRESENCE OF MEDICALLY NEEDY PROGRAM	SPEND DOWN TIME PERIOD (in months)	ALLOWABLE RESOURCES One Person	ALLOWABLE RESOURCES Two Person	ALLOWABLE RESOURCES Four Person	PROTECTED INCOME One Person	PROTECTED INCOME Two Person	PROTECTED INCOME Four Person
ALABAMA	-							
ALASKA	-							
ARKANSAS	X	3	$1,500	$2,250	$2,450	$150	$158	$225
CALIFORNIA	X	1	$1,500	$2,250	$2,400	$331	$544	$301
COLORADO	-							
CONNECTICUT	X	6	$1,500	$2,250	$2,450	$333	$450	$600
DELAWARE	-							
DIST COLUMBIA	X	**	**	**	**	$300	$314	$487
FLORIDA	-							
GEORGIA	-							
HAWAII	X	1	$1,500	$2,250	$2,750	$300	$400	$550
IDAHO	-							
ILLINOIS	X	6	$1,500	$2,250	$2,350	$238	$250	$368
INDIANA	-							
IOWA	-							
KANSAS	X	6	$1,800	$2,400	$3,200	$310	$390	$410
KENTUCKY	X	3	$1,500	$3,000	$3,100	$183	$217	$317
LOUISIANA	X	3	$1,500	$2,250	$2,300	$167	$192	$317
MAINE	X	6	$1,500	$2,250	$2,250	$270	$325	$433
MARYLAND	X	6	$2,500	$2,600	$2,800	$267	$309	$392
MASSACHUSETTS	X	6	$2,000	$3,000	$3,200	$333	$425	$445
MICHIGAN	X	6	$1,500	$2,250	$2,650	$309	$463	$492
MINNESOTA	X	6	$2,000	$4,000	$4,400	$313	$393	$556
MISSISSIPPI	-							
MISSOURI	-							
MONTANA	X	3	**	**	**	$285	$375	$425
NEBRASKA	X	6*	$1,500	$2,250	$2,300	$283	$375	$525
NEVADA	-							
NEW HAMPSHIRE***	X	6	$2,500	$4,000	$4,200	$249	$292	$392
NEW JERSEY	-							
NEW MEXICO	-							
NEW YORK	X	6	$2,600	$4,050	$5,150	$350	$509	$525
N CAROLINA	X	6	$1,500	$2,250	$2,450	$183	$242	$300
N DAKOTA	X	1	$8,000	$9,500	$9,550	$265	$385	$530
OHIO	-							
OKLAHOMA	X	6*	$1,500	$2,250	$2,450	$242	$292	$467
OREGON	-							
PENNSYLVANIA	X	6	$2,400	$3,200	$3,800	$316	$367	$458
RHODE ISLAND	X	6*	$4,000	$6,000	$6,200	$383	$425	$600
S CAROLINA	-							

TABLE 3.3.1 (Con't)

MEDICALLY NEEDY: FINANCIAL CRITERIA

STATE	PRESENCE OF MEDICALLY NEEDY PROGRAM	SPEND DOWN TIME PERIOD (in months)	ALLOWABLE RESOURCES One Person	ALLOWABLE RESOURCES Two Person	ALLOWABLE RESOURCES Four Person	PROTECTED INCOME One Person	PROTECTED INCOME Two Person	PROTECTED INCOME Four Person
S DAKOTA	-							
TENNESSEE	X	**	**	**	**	$117	$135	$205
TEXAS	-							
UTAH	X	1	$1,500	$2,250	$2,375	$287	$385	$607
VERMONT	X	6*	$1,500	$2,250	$2,550	$332	$514	$569
VIRGINIA	X	6	$1,500	$2,250	$2,450	$258	$317	$367
WASHINGTON	X	6*	$1,500	$2,250	$2,400	$323	$463	$531
W VIRGINIA	X	6	$1,500	$2,250	$2,350	$200	$225	$275
WISCONSIN	X	6	$1,500	$2,250	$2,850	$384	$542	$662
WYOMING	-							
TOTAL STATES	30							
SIMPLE AVERAGE		5	$2,030	$2,963	$3,236	$275	$356	$461

* There Are Exceptions to This Time Period
** Indicates Data Not Available or Not Reported
*** The protected income levels listed for New Hampshire are those for AFDC related recipients. Adult categories have protected income levels of $308 (1 person) and $413 (2 persons).

NOTE: Connecticut, Illinois, Louisiana, Michigan, Vermont, and Virginia have ranges for protected income. The highest income allowed is listed.

North Carolina has ranges for allowable resources. The highest resource level is listed.

This exhibit shows the wide variance in the protected income level by size of family among the States.

If a State chooses the medically needy option, the agency must provide Medicaid to (42 CFR 435.301):

- All pregnant women during the course of their pregnancy who, but for income and resources, would be eligible for Medicaid as categorically needy;
- All individuals or reasonable classifications of those individuals under age 21 (or, under age 20, 19, 18) who meet the income and resource standards as medically needy; and
- Blind and disabled individuals eligible in December 1973.

Pregnant women are covered by all 30 States offering a medically needy program as required by law (Table 3.3.2). This group includes pregnant women who would have been eligible for AFDC or for one of the other cash assistance programs except for income and resources. All individuals or reasonable classifications of individuals under age 21 (or, at State option, under age 20, 19, or 18) who are not AFDC recipients must be provided for in some manner. Note that the States have the discretion to target assistance by providing age range and reasonable classification choices of individuals under age 21 (42 CFR 435.308). Sixteen of the 30 medically needy States elected to cover all such individuals; three States electing "under age 18", one State electing "under age 19", and 12 States electing "under age 21." Sixteen States elected to cover reasonable classifications of individuals under age 21. Examples of reasonable classifications are:

- Individuals in foster homes or private institutions for whom a public agency is assuming full or partial financial responsibility. If the agency covers these individuals, it may also provide Medicaid to individuals placed in foster homes or private institutions by private non-profit agencies;
- Individuals in adoptions subsidized in full or in part by a public agency;
- Individuals in ICFs and, if those individuals are covered, the State may also provide Medicaid to individuals in ICF-MRs; and

Table 3.3.2

MEDICALLY NEEDY: ELIGIBILITY CRITERIA

STATE	PRESENCE OF MEDICALLY NEEDY PROGRAM	Pregnant Women	Individuals Under Age: All	Individuals Under Age: Reasonable Classifications	Caretaker Relatives	Aged	Blind	Disabled	Blind and Disabled who meet current eligibility requirements except for blindness or disability criteria and were eligible as Medically Needy in Dec 73 and for each month thereafter
ALABAMA	-	-	-	-	-	-	-	-	-
ALASKA	-	-	-	-	-	-	-	-	-
ARKANSAS	X	X	18	-	X	X	X	X	X
CALIFORNIA	X	X	21	-	X	X	X	X	X
COLORADO	-	-	-	-	-	-	-	-	-
CONNECTICUT	X	X	21	-	X	X	X	X	X
DELAWARE	-	-	-	-	-	-	-	-	-
DIST COLUMBIA	X	X	21	-	X	X	X	X	X
FLORIDA	-	-	-	-	-	-	-	-	-
GEORGIA	-	-	-	-	-	-	-	-	-
HAWAII	X	X	18	19	-	X	X	X	X
IDAHO	-	-	-	-	-	-	-	-	-
ILLINOIS	X	X	-	21	-	-	-	-	X
INDIANA	-	-	-	-	-	-	-	-	-
IOWA	-	-	-	-	-	-	-	-	-
KANSAS	X	X	-	21	X	X	X	X	X
KENTUCKY	X	X	-	19	X	X	X	X	X
LOUISIANA	X	X	19	21	X	X	X	X	X
MAINE	X	X	-	21	X	X	X	X	X
MARYLAND	X	X	21	-	X	X	X	X	X
MASSACHUSETTS	X	X	21	-	X	X	X	X	X
MICHIGAN	X	X	21	-	X	X	X	X	X
MINNESOTA	X	X	21	-	X	X	X	X	X
MISSISSIPPI	-	-	-	-	-	-	-	-	-
MISSOURI	-	-	-	-	-	-	-	-	-
MONTANA	X	X	-	21	X	X	X	X	X
NEBRASKA	X	X	-	21	X	X	X	X	X
NEVADA	-	-	-	-	-	-	-	-	-
NEW HAMPSHIRE	X	X	-	18	X	X	X	X	X
NEW JERSEY	-	-	-	-	-	-	-	-	-
NEW MEXICO	-	-	-	-	-	-	-	-	-
NEW YORK	X	X	21	-	X	X	X	X	X
N CAROLINA	X	X	-	19	X	X	X	X	X
N DAKOTA	X	X	21	-	X	X	X	X	X
OHIO	-	-	-	-	-	-	-	-	-
OKLAHOMA	X	X	21	-	X	X	X	X	X
OREGON	-	-	-	-	-	-	-	-	-
PENNSYLVANIA	X	X	21	-	X	X	X	X	X
RHODE ISLAND	X	X	-	19	X	X	X	X	X
S CAROLINA	-	-	-	-	-	-	-	-	-
S DAKOTA	-	-	-	-	-	-	-	-	-
TENNESSEE	X	X	-	21	NN	NN	NN	NN	X
TEXAS	-	-	-	-	-	-	-	-	-
UTAH	X	X	18	-	X	X	X	X	X
VERMONT	X	X	21	-	X	X	X	X	X
VIRGINIA	X	X	-	21*	-	X	X	X	X
WASHINGTON	X	X	-	21	X	X	X	X	X
W VIRGINIA	X	X	-	18	X	X	X	X	X
WISCONSIN	X	X	-	21*	-	X	X	X	X
WYOMING	-	-	-	-	-	-	-	-	-
TOTAL STATES	30	30	16	16	26	29	29	29	30
% RECIPIENTS FOR CATEGORY	100	100	79.2	21.8	90.6	94.5	94.5	94.5	100

* 21 for Some Classifications, 19 For Others

NN Indicates Data Not Reported or Not Available

- Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if inpatient psychiatric services for individuals under 21 are provided under the plan.

If Medicaid is provided to any individual in a group specified above, Medicaid must be provided to all individuals eligible to be members of that group. Note that in four States the age of the recipients varies by eligibility category. For example, Hawaii and Louisiana have chosen to cover all individuals under a given age (Hawaii- 18 years; Louisiana 19 years) and to cover selected classifications of individuals who are older (Hawaii - 19 years; Louisiana - 21 years). Two States, Virginia and Wisconsin, cover selected classification of individuals under 19 and other classifications of individuals under 21.

If the State provides Medicaid to the medically needy, it must provide coverage for blind and disabled individuals eligible in December 1973 (42 CFR 435.340). These individuals must meet all current requirements for Medicaid eligibility except the blindness or disability criteria, and were eligible as medically needy in December 1973 as blind or disabled, and for each consecutive month after December 1973 have continued to meet the December 1973 eligibility criteria. Thirty medically needy States are shown providing this coverage on Table 3.3.2.

A medically needy State may, at its own option, elect to cover any of the following groups of individuals:

- Caretaker relatives (42 CFR 435.310);
- Aged (42 CFR 435.320);
- Blind (42 CFR 435.322); and
- Disabled (42 CFR 435.324).

Caretaker relatives are those who meet the definition of caretaker relative and have in their care an individual who is determined to be dependent (42 CFR 435.310). Twenty-six of the 30 medically needy States have elected to cover this group. The 26 States account for 90.6 percent of the total medically needy recipients.

Aged, blind, and disabled individuals are covered by 29 medically needy States. Tennessee did not report data for these groups. The 29 States account for 94.5 percent of the total number of medically needy recipients.

4. SERVICE COVERAGE AND LIMITATIONS

Federal regulations pertaining to Medicaid mandate that certain basic services be offered to all categorically needy persons. These services include physician services, inpatient hospital services, outpatient hospital services, rural health clinic services, other laboratory and x-ray services, skilled nursing facility services for individuals 21 years of age and older, EPSDT, family planning services and supplies, home health services, and nurse-midwife services. States can also provide any number of certain additional services specified in the Federal regulations.

Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. The State plan must provide that the services obtainable by any individual in the categorically needy group are equal in amount, duration, and scope. The State plan must also provide that the services available to any categorically needy recipient under the plan are not less in amount, duration, and scope than those services available to a medically needy recipient. Certain limitations are specified in some cases. For example, SNF services in an institution for mental diseases are limited to persons 65 years of age or older. States receive Federal Financial Participation (FFP) for the basic services as well as the services covered at State option.

4.1 LIMITATIONS ON MANDATORY SERVICES

Tables 4.1.1 through 4.1.10 display limitations on mandatory services for the categorically needy by service. A unique schema for classifying groups of limitations has been developed for this study for each type of service and is based upon limitations as delineated in State Plans. This presents two complications which the reader should note: (1) There are differences within categories. (For example, "limited number of visits/year" varies by setting, by type of illness, whether the limit is included in a larger category encompassing all physician visits, and per recipient or per recipient by

hospital basis. Whenever possible the detailed information will be presented in the discussion or footnoted to overcome this complication.) (2) Certain categories for one service will overlap or be the same as categories for another service. For example, "limits on sterilization services" is a category for three mandatory services: inpatient hospital services, outpatient hospital services, and family planning services.

Some of the limitations on services specified by States were strictly those mandated by Federal regulations. For purposes of this discussion, we have tried to note only those limitations which are over and above those imposed by Federal regulations. Therefore, the category "No Limits" means that a State imposed no further restrictions in addition to those required by Federal law for a particular service.

At the bottom of each table is listed the "% total US $ for category." This line usually shows the percent of dollars expended for that particular service. For some services this information was not available (either because of the way expenditures were reported or because of questionable data) so instead, the percentage of total Medicaid expenditures will be shown and also this will be noted in the text for that particular service.

4.1.1 Inpatient Hospital Services

Inpatient hospital services mean services that are ordinarily furnished in a hospital for the care and treatment of an inpatient. The facility is one maintained primarily for the care and treatment of patients with disorders other than tuberculosis or mental diseases.

There are several general Federal limitations on inpatient hospital services which are applicable to all States with Medicaid programs (42 CFR 440.10):

- The facility must be licensed or formally approved as a hospital by an officially designated authority for State standard-setting;
- The facility must meet the requirements for participation in Medicaid;
- The care and treatment of inpatients must be under the direction of a physician or dentist; and
- The facility must have in effect an approved utilization review plan, applicable to all Medicaid patients, unless a waiver has been granted by the Secretary.

In addition to the Federal limitations, each State may impose further limitations on inpatient hospital services. As of March 1983, five States had chosen to impose no further limitations on inpatient hospital services. Forty-four States and the District of Columbia chose to impose restrictions fitting one or more of the 11 limitation categories displayed on Table 4.1.1.

Sixteen States placed a limit on the number of days a recipient is covered for inpatient hospital services. The 16 States account for 21.7 percent of the total Medicaid expenditures for inpatient hospital services for 50 jurisdictions. The majority of these States limit the number of reimbursable days per year. However, six States impose a day limit based on other criteria. Kentucky and Oklahoma base their day limit on a per admission basis; readmissions in Oklahoma must be separated by 20 days from the date of discharge. Maryland, Ohio, and Texas limit days per spell of illness while South Dakota limits days per benefit period. Michigan does not limit inpatient days per year but it does require prior authorization for stays beyond 18 days. Since this restriction does not fit the "limits on number of days per year" category, nothing is marked for Michigan in this column.

Nineteen States, which account for 35.9 percent of total Medicaid expenditures on inpatient services for all jurisdictions, require prior authorization for certain specific procedures. Alaska, however, is the only State which requires prior authorization on all elective procedures.

Limits on pre-operative days and/or weekend admissions are imposed by 11 States accounting for 35.9 percent of total Medicaid inpatient hospital expenditures. Florida is the only State that has a policy of not covering elective surgery. However, 15 States do not cover specific procedures and six States do not cover procedures that could be provided on an outpatient basis. Some optional hospital services such as television, telephone and private rooms are not covered by seven States accounting for 13.6 percent of the total expenditures. Six States place limits on dental procedures and limits are placed on sterilization services by four States.

Table 4.1.1

SUMMARY OF LIMITATIONS ON MANDATORY SERVICES
INPATIENT HOSPITAL SERVICES

STATE	No Limits	Limits On Number Of Days/Year	Prior Authorization Required: All Elective Procedures	Prior Authorization Required: Certain Specific Procedures	Limits On Pre-Operative Days/Weekend Admissions	Elective Surgery Not Covered	Specific Procedures Not Covered	Procedures That Could Be Provided On An Outpatient Basis Not Covered	Some Optional Hospital Services Not Covered	Limits On Dental Procedures	Limits On Sterilization Services	Other Limits
ALABAMA	-	15	-	X	X	-	-	-	-	X	-	X
ALASKA	-	-	X	X	-	-	-	-	-	-	-	X
ARKANSAS	-	-	-	-	-	-	-	-	-	-	-	X
CALIFORNIA	-	-	-	X	-	-	X	X	-	-	-	-
COLORADO	-	-	-	-	-	-	-	-	-	-	-	X
CONNECTICUT	-	-	-	-	-	-	X	-	-	-	-	-
DELAWARE	X	-	-	-	-	-	-	-	-	-	-	-
DIST COLUMBIA	-	-	-	X	-	-	-	-	-	X	-	X
FLORIDA	-	45	-	-	-	X	X	-	-	-	-	-
GEORGIA	-	25	-	X	X	-	-	-	X	-	X	-
HAWAII	-	-	-	X	-	-	-	-	-	-	-	X
IDAHO	-	60	-	-	-	-	-	-	-	-	-	-
ILLINOIS	-	-	-	-	X	-	-	X	-	-	-	-
INDIANA	-	-	-	X	-	-	-	-	-	-	-	-
IOWA	-	-	-	X	-	-	X	-	X	X	-	-
KANSAS	-	-	-	-	X	-	X	-	-	-	-	X
KENTUCKY	-	14*	-	-	X	-	X	X	-	-	-	X
LOUISIANA	-	-	-	-	-	-	-	-	-	-	-	X
MAINE	-	30	-	-	-	-	-	-	-	-	-	X
MARYLAND	-	20*	-	X	X	-	X	-	X	-	-	X
MASSACHUSETTS	X	-	-	-	-	-	-	-	-	-	-	-
MICHIGAN	-	-	-	X	-	-	X	X	X	X	-	X
MINNESOTA	-	-	-	-	-	-	-	-	-	-	-	X
MISSISSIPPI	-	30	-	-	X	-	-	-	-	-	-	-
MISSOURI	-	-	-	-	X	-	-	-	-	-	-	X
MONTANA	X	-	-	-	-	-	-	-	-	-	-	-
NEBRASKA	-	-	-	X	-	-	-	-	-	-	-	X
NEVADA	-	-	-	-	-	-	-	-	-	-	-	X
NEW HAMPSHIRE	X	-	-	-	-	-	-	-	-	-	-	-
NEW JERSEY	-	-	-	-	-	-	X	-	-	-	-	X
NEW MEXICO	-	-	-	X	-	-	-	-	-	-	-	X
NEW YORK	-	-	-	-	X	-	-	X	-	-	-	X
N CAROLINA	-	-	-	X	-	-	-	-	X	-	-	X
N DAKOTA	X	-	-	-	-	-	-	-	-	-	-	-
OHIO	-	30*	-	-	-	-	X	-	-	-	-	X
OKLAHOMA	-	10*	-	-	-	-	-	-	-	-	-	X
OREGON	-	18	-	X	-	-	-	-	-	-	-	-
PENNSYLVANIA	-	-	-	-	-	-	X	X	-	X	X	-
RHODE ISLAND	-	-	-	X	-	-	X	-	-	-	-	X
S CAROLINA	-	12	-	X	-	-	X	-	-	-	X	-
S DAKOTA	-	60	-	-	-	-	-	-	-	-	-	-
TENNESSEE	-	14	-	-	X	-	-	-	-	-	-	-
TEXAS	-	30*	-	-	-	-	-	-	X	-	-	-
UTAH	-	-	-	X	-	-	-	-	-	-	X	X
VERMONT	-	-	-	X	-	-	X	-	X	X	-	-
VIRGINIA	-	-	-	-	X	-	-	-	-	-	-	X
WASHINGTON	-	-	-	-	-	-	-	-	-	-	-	X
W VIRGINIA	-	20	-	-	-	-	-	-	-	-	-	-
WISCONSIN	-	-	-	X	-	-	-	-	-	-	-	X
WYOMING	-	-	-	-	-	-	X	-	-	-	-	-
TOTAL STATES	5	16	1	19	11	1	15	6	7	6	4	27
% TOTAL U.S.	6.1	21.7	0.1	35.9	35.9	2.3	42.5	51.4	13.6	12.9	8.2	52.3

* Per Spell of Illness

Twenty-seven States accounting for 52.3 percent of the total Medicaid expenditures for inpatient hospital services for the 50 jurisdictions place other limits on inpatient hospital services. Examples of "other limits" imposed by States include:

- Alaska requires prior authorization for non-emergency and out-of-State hospitalizations;
- Colorado provides emergency hospital services only when necessary to prevent death or serious impairment;
- Kentucky requires laboratory tests to be done on a preadmission basis where feasible;
- Missouri and New Jersey require a second opinion for certain elective procedures; and
- Wisconsin limits inpatient psychiatric care to the month of admission with no readmissions earlier than 90 days from the prior admission.

This category includes States that might have only one "other limit" as well as States that have several "other limits."

A frequency distribution showing the number of limitation categories imposed by States is shown in Figure 1 and Figure 2 shows the percent of total Medicaid expenditures by number of limitation categories imposed on inpatient hospital services. Ten percent of the States representing less than five percent of total Medicaid expenditures imposed no limitations. Twenty-four percent of the States elected to impose one limitation category, 28 percent had two limitation categories, 20 percent imposed three limitation categories and accounted for 41 percent of total Medicaid expenditures, 8 percent had four limitation categories, and ten percent imposed more than four limitation categories.

FIGURE 1

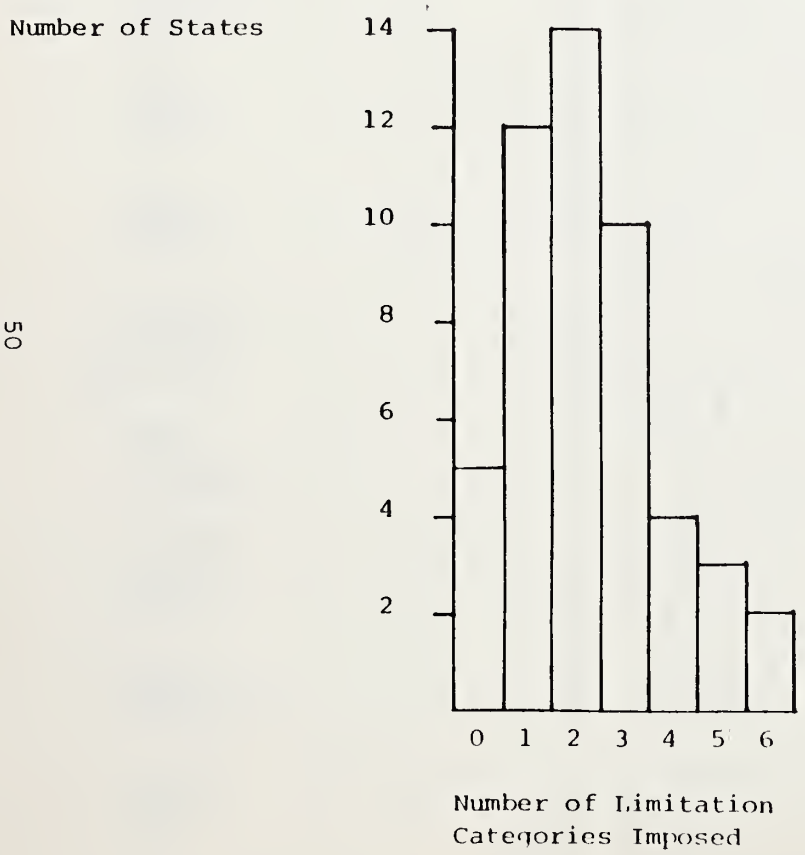
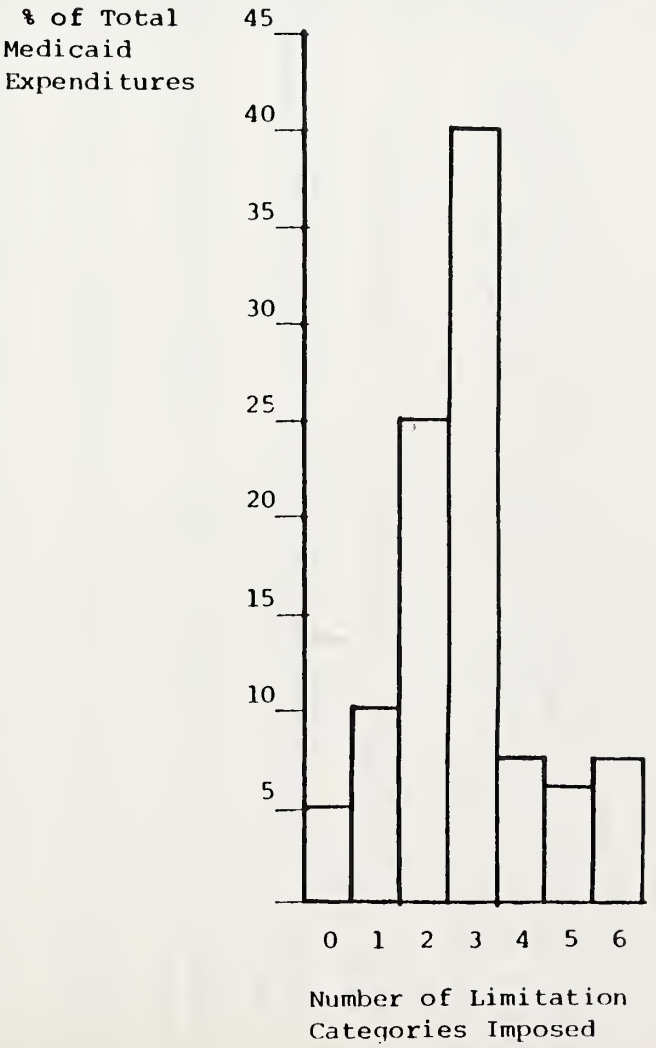


FIGURE 2



Caution should be exercised when interpreting these data of limitations on inpatient hospital services. It is possible that a State imposing one type of limitation is more stringent than a State imposing several types of limitations. It is also possible that two States with exactly the same limitation(s) will vary greatly in implementation procedures. Further, absolute numbers of States or numbers of limitations do not reflect the magnitude of the impact of the limitations without examination of other Medicaid program characteristics, statistics, and exogenous variables.

4.1.2 Outpatient Hospital Services

Outpatient hospital services mean preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided to an outpatient. There are three Federal limitations that are imposed on these services:

- The services must be provided under the direction of a physician or dentist;
- The facility must be licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and
- The facility must meet the requirements for participation in Medicare.

States are free to specify other limits on outpatient hospital services and 39 States plus the District of Columbia have chosen to do so. Table 4.1.2 displays limitations on outpatient hospital services.

Twelve States limit the number of visits per year allowable for Medicaid reimbursement and these 12 States account for 14.4 percent of the total Medicaid expenditures for outpatient hospital services. Alabama, Arkansas, Nevada, New Hampshire and Tennessee simply limit the number of outpatient hospital visits per year; Georgia and Missouri limit outpatient visits per month; and the remaining States have more detailed limitations. Idaho limits emergency room visits to six per year. Mississippi also limits emergency room visits to 6 per year plus outpatient visits which are limited within the 18 physician visits per year. South Carolina includes in its limit of 18 visits not only outpatient visits but also physician and emergency hospital visits. North Carolina counts visits to clinics, physicians, outpatient hospitals,

Table 4.1.2

SUMMARY OF LIMITATIONS ON MANDATORY SERVICES
OUTPATIENT HOSPITAL SERVICES

STATE	No Limits	Limited Number Of Visits/Year	Some Procedures/ Special Services Not Covered	Prior Authorization Required For Certain Services/Procedures	Limits On Psychiatric Services	Limits On Sterilization Services	Other Limits
ALABAMA	-	6	-	X	-	-	-
ALASKA	X	-	-	-	-	-	-
ARKANSAS	-	12	-	-	-	-	-
CALIFORNIA	-	-	X	-	-	-	X
COLORADO	-	-	X	-	-	-	-
CONNECTICUT	-	-	X	-	-	-	X
DELAWARE	X	-	-	-	-	-	-
DIST COLUMBIA	-	-	-	X	-	-	X
FLORIDA	-	-	-	-	-	-	X
GEORGIA	-	12	X	-	-	-	X
HAWAII	-	-	-	-	X	-	-
IDAHO	-	6	-	-	-	-	-
ILLINOIS	X	-	-	-	-	-	-
INDIANA	-	-	-	X	-	-	-
IOWA	-	-	-	-	-	-	X
KANSAS	-	-	X	X	X	-	X
KENTUCKY	-	-	-	-	-	-	X
LOUISIANA	-	-	-	-	-	-	X
MAINE	X	-	-	-	-	-	-
MARYLAND	-	-	X	X	X	-	X
MASSACHUSETTS	X	-	-	-	-	-	-
MICHIGAN	-	-	X	X	X	-	X
MINNESOTA	-	-	X	-	-	-	-
MISSISSIPPI	-	18	-	-	-	-	X
MISSOURI	-	24	-	X	-	-	X
MONTANA	X	-	-	-	-	-	-
NEBRASKA	-	-	X	-	X	-	X
NEVADA	-	24	-	-	-	-	X
NEW HAMPSHIRE	-	12	-	-	-	-	-
NEW JERSEY	-	-	X	X	-	-	X
NEW MEXICO	-	-	-	X	-	-	-
NEW YORK	X	-	-	-	-	-	-
N CAROLINA	-	24	X	-	X	-	X
N DAKOTA	X	-	-	-	-	-	-
OHIO	-	48	-	-	-	-	-
OKLAHOMA	-	-	-	-	-	-	X
OREGON	-	-	-	X	-	-	-
PENNSYLVANIA	-	-	-	X	-	-	X
RHODE ISLAND	-	-	-	X	-	-	-
S CAROLINA	-	18	-	-	-	-	-
S DAKOTA	X	-	-	-	-	-	-
TENNESSEE	-	30	-	-	-	-	-
TEXAS	-	-	X	-	-	-	X
UTAH	-	-	-	-	-	X	-
VERMONT	-	-	-	-	-	-	X
VIRGINIA	-	-	-	-	-	-	X
WASHINGTON	X	-	-	-	-	-	-
W VIRGINIA	-	-	-	-	-	-	X
WISCONSIN	-	-	-	X	X	-	X
WYOMING	-	-	X	-	-	-	-
TOTAL STATES	10	12	13	13	7	1	24
% TOTAL U S 6 FOR CATEGORY	40.6	14.4	32.3	22.0	10.8	0.2	45.3

chiropractors, podiatrists, and optometrists in their limit of 24 visits per year. Ohio limits visits to four per month. While Pennsylvania did not specify a limit on visits per year, visits for prenatal care are limited to a total of 12 and one visit is allowed to establish a diagnosis of tuberculosis.

Some procedures and/or special services are not covered by 13 States accounting for 32.3 percent of total Medicaid expenditures for outpatient hospital services. Examples of such procedures are routine physical examinations, experimental procedures, and psychiatric day hospitals.

Prior authorization is required for certain services and/or procedures in 13 States accounting for 22.0 percent of total Medicaid expenditures for outpatient hospital services. The services/procedures for which prior authorization is required are generally ancillary rather than primary care services.

Seven States have limits on psychiatric services but only one State, Utah, placed limits on sterilization services.

Twenty-four States, those States accounting for 45.3 percent of total Medicaid expenditures for outpatient hospital services, placed other limits on outpatient hospital services. Examples of "other limits" include: (1) emergency room services are not provided between 8:00 a.m. and 4:00 p.m. in Vermont except for trauma and (2) outpatient services are limited to a maximum of $500 per fiscal year in Florida.

4.1.3 Rural Health Clinic Services

Rural health clinic (RHC) services became a mandatory service for the categorically needy in July 1978. Each RHC is required to have a nurse practitioner (NP) or physician's assistant (PA) on its staff. Therefore, a clinic can only be certified if the State permits the delivery of primary care by an NP or PA. Services in certified clinics must be provided and furnished by a physician or by a PA, NP, nurse-midwife, or other specialized nurse practitioner. Services and supplies are furnished as an incident to professional services. Part-time or intermittent visiting nurse care and related medical supplies are provided given that the clinic is located in a Health Manpower

Shortage Area, the services are furnished by nurses employed by the clinic, and the services are furnished under a written plan of treatment to a homebound recipient.

Fourteen States have placed no limits on RHC services (Table 4.1.3). These 14 States account for 38.9 percent of the total Medicaid expenditures for all services. (Note that on most tables "% US $" is based on dollars for that specific service. RHC expenditures as reported on the HCFA-2082 statistical report are not used because of State problems in reporting the data.) Prior authorization is required for certain services/procedures by five States such as medical equipment and ambulatory services at other settings. Seven States place limits on number of visits per year. In general, these RHC visits are included in the total number of physician visits allowed per year. Seven States place limits on specific services and four States place "other limits" on RHC services.

Some States prohibit or restrict the practice of NPs and PAs. One form of restriction is requiring direct supervision of NPs and/or PAs by a physician. Although most States do not explicitly prohibit the delivery of primary care by an NP or PA, many States do not specifically recognize one or both of these practitioners, and the circumstances surrounding their practice is sometimes vague. Some States do not specifically recognize NPs but do recognize nursing in an expanded role. Thus, for the category "services provided by non-physicians limited or not covered," a total of ten States impose limitations. The ten States account for 42.6 percent of the total Medicaid expenditures for all services. There are 16 States where RHC services are not provided to Medicaid recipients. These 16 States account for 28.2 percent of total Medicaid expenditures for all services.

4.1.4 Other Laboratory and X-Ray Services

Other laboratory and x-ray services are professional and technical laboratory and radiological services. As specified in 42 CFR 440.30(a-c), Federal requirements for Medicaid mandate that these services be:

Table 4.1.3

SUMMARY OF LIMITATIONS ON MANDATORY SERVICES
RURAL HEALTH CLINIC SERVICES

STATE	No Limits	Prior Authorization Required For Certain Services/Procedures	Limited Number Of Visits/Year	Limits On Specific Services	Other Limits	Services Provided By Non-Physicians Limited Or Not Covered	Not Provided
ALABAMA	X	-	-	-	-	-	-
ALASKA	X	-	-	-	-	-	-
ARKANSAS	-	-	12	-	-	-	-
CALIFORNIA	-	-	-	-	X	X	-
COLORADO	X	-	-	-	-	X	-
CONNECTICUT	-	-	-	-	-	-	X
DELAWARE	-	-	-	-	-	-	X
DIST COLUMBIA	-	-	-	-	-	-	X
FLORIDA	-	-	-	-	-	X	-
GEORGIA	X	-	-	-	-	X	-
HAWAII	-	-	-	-	-	-	X
IDAHO	X	-	-	-	-	-	-
ILLINOIS	-	-	-	-	-	-	X
INDIANA	-	-	-	-	-	-	X
IOWA	-	-	-	X	-	-	-
KANSAS	-	X	36	-	X	-	-
KENTUCKY	-	-	-	-	X	X	-
LOUISIANA	-	-	-	-	-	-	X
MAINE	X	-	-	-	-	-	-
MARYLAND	-	-	-	X	-	-	-
MASSACHUSETTS	X	-	-	-	-	-	-
MICHIGAN	-	-	-	-	-	-	X
MINNESOTA	-	-	-	-	-	-	X
MISSISSIPPI	-	-	18	-	X	X	-
MISSOURI	-	-	-	-	-	-	X
MONTANA	-	-	-	-	-	-	X
NEBRASKA	-	-	-	-	-	-	X
NEVADA	-	-	-	X	-	-	-
NEW HAMPSHIRE	-	-	12	-	-	-	-
NEW JERSEY	-	-	-	-	-	-	X
NEW MEXICO	-	X	-	-	-	-	-
NEW YORK	X	-	-	-	-	X	-
N CAROLINA	-	X	24	X	-	-	-
N DAKOTA	-	-	-	-	-	-	X
OHIO	-	-	48	-	-	-	-
OKLAHOMA	-	-	-	X	-	-	-
OREGON	-	-	-	-	-	X	-
PENNSYLVANIA	X	-	-	-	-	-	-
RHODE ISLAND	-	X	-	-	-	-	-
S CAROLINA	-	-	18	-	-	-	-
S DAKOTA	X	-	-	-	-	-	-
TENNESSEE	X	-	-	-	-	-	-
TEXAS	-	-	-	-	-	-	X
UTAH	X	-	-	-	-	-	-
VERMONT	-	-	-	X	-	X	-
VIRGINIA	-	-	-	-	-	-	X
WASHINGTON	X	-	-	-	-	-	-
W VIRGINIA	X	-	-	-	-	-	-
WISCONSIN	-	X	-	-	-	X	-
WYOMING	-	-	-	X	-	-	-
TOTAL STATES	14	5	7	7	4	10	16
% TOTAL U.S. $ FOR CATEGORY	38.9	6.2	9.5	5.7	14.7	42.6	28.2

- Ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law or ordered and billed by a physician but provided by an independent laboratory;

- Provided in an office or similar facility other than a hospital outpatient department or clinic; and

- Provided by a laboratory that meets the requirements for participation in Medicare.

In addition, the States can place limitations on "other laboratory and x-ray services." However, 28 of the 50 jurisdictions have chosen to place no limitations on these services (Table 4.1.4). The 28 States account for 52.2 percent of total Medicaid expenditures for "other laboratory and x-ray services."

Three States require prior authorization, four States limit services to those ordered by a physician, and twelve States limit or require prior approval on some procedures. The States in each one of these categories of limitations account for less than 12 percent of total Medicaid expenditures for "other laboratory and x-ray services."

"Other limits" are imposed by seven States accounting for 28.8 percent of total Medicaid expenditures for "other laboratory and x-ray services." "Other limits" include services allowed only within 24 hours of acute injury and must be directly related to that injury and reimbursement for services will not be made to a private laboratory if services could be obtained from the Department of Health Laboratory.

4.1.5 Skilled Nursing Facility Services

Skilled nursing facility (SNF) services are provided to individuals age 21 or older and do not include services in institutions for tuberculosis or mental diseases (42 CFR 440.40(a)). These services must be needed on a daily basis and provided in an inpatient facility. Federal regulations require that the services be:

- Provided by a facility or distinct part of a facility that is certified to meet the requirements for participation. These requirements include provider agreements, facility certification, and facility standards; and

- Ordered by and under the direction of a physician.

Table 4.1.4

SUMMARY OF LIMITATIONS ON MANDATORY SERVICES
OTHER LABORATORY AND X-RAY SERVICES

STATE	No Limits	Prior Authorization Required	Limited To Services Ordered By Physician	Some Procedures Limited Or Require Prior Approval	Other Limits
ALABAMA	X	-	-	-	-
ALASKA	-	-	X	-	-
ARKANSAS	-	X	-	-	-
CALIFORNIA	-	-	-	-	X
COLORADO	X	-	-	-	-
CONNECTICUT	-	-	-	X	-
DELAWARE	X	-	-	-	-
DIST COLUMBIA	-	X	-	X	X
FLORIDA	-	-	X	-	-
GEORGIA	-	-	-	X	-
HAWAII	-	X	-	-	-
IDAHO	X	-	-	-	-
ILLINOIS	X	-	-	-	-
INDIANA	X	-	-	-	-
IOWA	-	-	-	X	-
KANSAS	-	-	-	X	-
KENTUCKY	-	-	X	-	-
LOUISIANA	X	-	-	-	-
MAINE	X	-	-	-	-
MARYLAND	-	-	-	X	X
MASSACHUSETTS	X	-	-	-	-
MICHIGAN	X	-	-	-	-
MINNESOTA	X	-	-	-	-
MISSISSIPPI	X	-	-	-	-
MISSOURI	-	-	-	X	-
MONTANA	X	-	-	-	-
NEBRASKA	X	-	-	-	-
NEVADA	X	-	-	-	-
NEW HAMPSHIRE	-	-	-	-	X
NEW JERSEY	X	-	-	-	-
NEW MEXICO	X	-	-	-	-
NEW YORK	X	-	-	-	-
N CAROLINA	X	-	-	-	-
N DAKOTA	X	-	-	-	-
OHIO	X	-	-	-	-
OKLAHOMA	-	-	-	-	X
OREGON	-	-	-	X	-
PENNSYLVANIA	-	-	-	X	-
RHODE ISLAND	-	-	-	X	X
S CAROLINA	X	-	-	-	-
S DAKOTA	X	-	-	-	-
TENNESSEE	-	-	-	-	X
TEXAS	-	-	X	-	-
UTAH	-	-	-	X	-
VERMONT	X	-	-	-	-
VIRGINIA	X	-	-	-	-
WASHINGTON	-	-	-	X	-
W VIRGINIA	X	-	-	-	-
WISCONSIN	X	-	-	-	-
WYOMING	X	-	-	-	-
TOTAL STATES	28	3	4	12	7
% TOTAL U.S. $ FOR CATEGORY	52.2	1.3	9.0	10.9	28.8

These services include services provided by any facility located on an Indian reservation and certified by the Secretary of Health and Human Services. Further, the requirements concerning control of the utilization of Medicaid services impact upon skilled nursing facility services on such areas as certification and recertification of need for inpatient care, individuals written plan of care, etc.

Limitations on skilled nursing facility services are displayed on Table 4.1.5. Caution should be taken in interpreting the data in "prior authorization required" and "periodic reauthorization." There are two problems: (1) There is no consistent usage of the terms certification and authorization across States; and (2) Some States have apparently included in limitations certain Federal regulations. Some States appear to use certification and authorization interchangeably while other States differentiate between the terms. Generally, certification means determination of medical need by a medical practitioner(s) and authorization means approval for payment by an administrative body (possibly with a medical practitioner member). Only those States using the terms authorization and reauthorization are noted in the table. Further, the Federal regulations for utilization control include intermediate care facility certification and periodic recertification of need for inpatient care. Thus, the statement that a State requires certification and periodic recertification is merely a reiteration of a Federal requirement and not a State limitation and is therefore not noted in the table.

Seventeen States impose no limits on SNF services and those States expend only 23.8 percent of the total Medicaid expenditures for SNF services. Twenty-two States require prior authorization for payment with eight of the 22 requiring periodic reauthorization. The States requiring prior authorization account for 59.8 percent of the total Medicaid expenditures for SNF services. Twelve States impose "other limits" on SNF services. These "other limits" include restrictions on private rooms, SNF services outside the State, specific services, bed reservations when on leave or in another facility, administrative days, etc. These 12 States account for 16.4 percent of the total Medicaid expenditures for SNF services.

Table 4.1.5

SUMMARY OF LIMITATIONS ON MANDATORY SERVICES
SKILLED NURSING FACILITY SERVICES

STATE	No Limits	Prior Authorization Required	Periodic Reauthorization Required	Other Limits
ALABAMA	-	X	-	-
ALASKA	-	X	-	-
ARKANSAS	-	X	-	-
CALIFORNIA	-	X	X	-
COLORADO	-	X	X	-
CONNECTICUT	X	-	-	-
DELAWARE	X	-	-	-
DIST COLUMBIA	-	-	-	X
FLORIDA	X	-	-	-
GEORGIA	-	X	-	-
HAWAII	-	X	-	-
IDAHO	X	-	-	-
ILLINOIS	X	-	-	-
INDIANA	-	X	-	-
IOWA	-	-	-	X
KANSAS	X	-	-	-
KENTUCKY	-	X	X	-
LOUISIANA	X	-	-	-
MAINE	-	-	-	X
MARYLAND	-	X	-	X
MASSACHUSETTS	-	-	-	X
MICHIGAN	-	X	X	-
MINNESOTA	X	-	-	-
MISSISSIPPI	-	X	-	-
MISSOURI	-	X	X	-
MONTANA	X	-	-	-
NEBRASKA	-	-	-	X
NEVADA	-	X	-	-
NEW HAMPSHIRE	-	X	X	-
NEW JERSEY	-	X	X	-
NEW MEXICO	X	-	-	-
NEW YORK	-	X	-	-
N CAROLINA	-	X	-	-
N DAKOTA	X	-	-	-
OHIO	-	-	-	X
OKLAHOMA	-	-	-	X
OREGON	-	-	-	X
PENNSYLVANIA	X	-	-	-
RHODE ISLAND	-	X	-	-
S CAROLINA	-	X	-	-
S DAKOTA	X	-	-	-
TENNESSEE	X	-	-	-
TEXAS	-	-	-	X
UTAH	X	-	-	-
VERMONT	-	-	-	X
VIRGINIA	X	-	-	-
WASHINGTON	-	X	-	-
W VIRGINIA	-	X	X	-
WISCONSIN	-	-	-	X
WYOMING	X	-	-	-
TOTAL STATES	17	22	8	12
% TOTAL U.S. $ FOR CATEGORY	23.8	59.8	18.9	16.4

4.1.6 Early and Periodic Screening, Diagnosis and Treatment

Early and periodic screening, diagnosis and treatment (EPSDT) means screening and diagnostic services to determine physical or mental defects in recipients under age 21 and health care, treatment and other measures to correct or amelioriate any defects and chronic conditions discovered (42 CFR 440.40(b)). There are certain basic screening and treatment services that each State must provide as a minimum (42 CFR 441.56). These services include:

- Health and development history screening;
- Unclothed physical examination;
- Developmental assessment;
- Immunizations which are appropriate for age and health history;
- Assessment of nutritional status;
- Vision testing;
- Hearing testing;
- Laboratory procedures appropriate for age and population groups;
- Dental services furnished by direct referral to a dentist for diagnosis and treatment for children three years of age and over;
- Treatment for defects in vision and hearing, including eyeglasses and hearing aids; and
- Dental care needed for relief of pain and infections, restoration of teeth and maintenance of dental health.

The State Medicaid Agency may provide for any other medical or remedial care specified as a Medicaid service even if the agency does not otherwise provide for these services to other recipients or provides for them in a lesser amount, duration, or scope.

Table 4.1.6 displays a summary of limitations on EPSDT services. Twenty-seven States, accounting for 42.7 percent of total Medicaid expenditures for EPSDT services, limit their services to the coverage and scope as required by Federal regulations. Nine States (41.8 percent of total

Table 4.1.6

SUMMARY OF LIMITATIONS ON MANDATORY SERVICES
EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT

STATE	Limited to Federal Requirements	In Excess of Federal Requirements	No Limits
ALABAMA	-	X	-
ALASKA	-	X	-
ARKANSAS	-	X	-
CALIFORNIA	-	X	-
COLORADO	X	-	-
CONNECTICUT	-	-	X
DELAWARE	-	-	X
DIST COLUMBIA	-	-	X
FLORIDA	X	-	-
GEORGIA	X	-	-
HAWAII	X	-	-
IDAHO	X	-	-
ILLINOIS	X	-	-
INDIANA	X	-	-
IOWA	-	-	X
KANSAS	-	-	X
KENTUCKY	X	-	-
LOUISIANA	X	-	-
MAINE	X	-	-
MARYLAND	X	-	-
MASSACHUSETTS	X	-	-
MICHIGAN	-	X	-
MINNESOTA	-	X	-
MISSISSIPPI	X	-	-
MISSOURI	X	-	-
MONTANA	-	-	X
NEBRASKA	X	-	-
NEVADA	-	-	X
NEW HAMPSHIRE	X	-	-
NEW JERSEY	X	-	-
NEW MEXICO	X	-	-
NEW YORK	-	-	X
N CAROLINA	X	-	-
N DAKOTA	-	-	X
OHIO	X	-	-
OKLAHOMA	-	X	-
OREGON	X	-	-
PENNSYLVANIA	X	-	-
RHODE ISLAND	-	X	-
S CAROLINA	X	-	-
S DAKOTA	-	X	-
TENNESSEE	X	-	-
TEXAS	X	-	-
UTAH	-	-	X
VERMONT	X	-	-
VIRGINIA	-	-	X
WASHINGTON	-	-	X
W VIRGINIA	-	-	X
WISCONSIN	-	-	X
WYOMING	X	-	-
TOTAL STATES	27	9	14
% TOTAL U.S. $ FOR CATEGORY	42.7	41.8	15.6

Medicaid expenditures) offer EPSDT services in excess of Federal requirements and 14 States (15.6 percent of total Medicaid expenditures) have no limits on EPSDT services.

4.1.7 Family Planning Services

Family planning services and supplies are allowable for individuals of child bearing age as a means of enabling individuals to freely determine the number and spacing of their children. Although there are no Federal regulations defining what family planning services a State can provide, provisional regulations were written which defined family planning services to be: consultation (including counseling and patient education), examination, and treatment, furnished by or under the supervision of a physician or prescribed by a physician; laboratory examination; medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception; natural family planning methods; diagnosis and treatment for infertility; and voluntary sterilizations. In addition, States may provide any medically approved means, other than abortion, for family planning purposes, if furnished by or under supervision of a physician or if prescribed by a physician. Abortions are specifically excluded from family planning services and States are prohibited from considering any abortion as being a family planning service.

Table 4.1.7 shows that family planning services are provided without limitations by 38 States and those States account for 69.3 percent of the total Medicaid expenditures for family planning services. It should be noted that in all States family planning services are subject to limitations of each service category under which it falls; i.e., family planning services rendered by a physician are also subject to the same State agency program limitations imposed on physicians' services.

Voluntary sterilizations must be included among the range of family planning services offered by a State. Federal regulations require that the individual to be sterilized voluntarily gives informed written consent and that the individual must be at least 21 years of age at the time consent is obtained and must be mentally competent. In most cases, guidelines further require that at least 30 days but not more than 180 days have passed between

Table 4.1.7

SUMMARY OF LIMITATIONS ON MANDATORY SERVICES
FAMILY PLANNNING SERVICES

STATE	No Limits	Limits on Sterilization Services	Other Limits
ALABAMA	X	-	-
ALASKA	X	-	-
ARKANSAS	-	-	X
CALIFORNIA	X	-	-
COLORADO	X	-	-
CONNECTICUT	X	-	-
DELAWARE	X	-	-
DIST COLUMBIA		-	-
FLORIDA		-	-
GEORGIA	X	-	-
HAWAII	X	-	-
IDAHO	X	-	-
ILLINOIS	X	-	-
INDIANA	X	-	-
IOWA	-	-	X
KANSAS	X	-	-
KENTUCKY	-	-	X
LOUISIANA	X	-	-
MAINE	X	-	-
MARYLAND	X	-	-
MASSACHUSETTS	X	-	-
MICHIGAN	-	-	X
MINNESOTA	-	-	X
MISSISSIPPI	X	-	-
MISSOURI	X	-	-
MONTANA	X	-	-
NEBRASKA	X	-	-
NEVADA	X	-	-
NEW HAMPSHIRE	X	-	-
NEW JERSEY	X	-	-
NEW MEXICO	X	-	-
NEW YORK	X	-	-
N CAROLINA	X	-	-
N DAKOTA	X	-	-
OHIO	X	-	-
OKLAHOMA	X	-	-
OREGON	X	-	-
PENNSYLVANIA	-	-	X
RHODE ISLAND	-	-	X
S CAROLINA	X	-	-
S DAKOTA	X	-	-
TENNESSEE	X	-	-
TEXAS	-	-	X
UTAH	-	X	-
VERMONT	-	-	X
VIRGINIA	-	-	X
WASHINGTON	X	-	-
W VIRGINIA	X	-	-
WISCONSIN	-	X	-
WYOMING	X	-	-
TOTAL STATES	38	2	10
% TOTAL U.S. $ FOR CATEGORY	69.3	2.8	27.9

the date of informed consent and the date of sterilization. In addition to these Federal regulations, two States - Utah and Wisconsin - require prior authorization for sterilization services. These two States expend only 2.8 percent of all Medicaid expenditures for family planning services.

Other limits are imposed by ten States accounting for 27.9 percent of total Medicaid expenditures for family planning services. Other limits include restrictions on specific provider settings, limits on drugs determined by FDA to be ineffective, and most commonly, restrictions on the number of visits/services per year.

4.1.8 Physicians' Services

Physicians' services are covered whether provided in the office, the patient's home, a hospital, a skilled nursing facility, or elsewhere. Physicians' services must be within the scope of practice of medicine or osteopathy as defined by State law and by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

Limitations on physicians' services are found on Tables 4.1.8(A)-(D). Seven States accounting for 15.7 percent of total Medicaid expenditures for physician services place no limits on physician services as shown in Table 4.1.8(A). Twenty-three States do not cover specific services such as transplants, autopsies, cosmetic surgery, experimental procedures, and routine physicals. These 23 States account for 58.6 percent of total Medicaid expenditures for physician services. Limits are placed on injections in seven States. These States account for 30.2 percent of the total Medicaid expenditures for physician services. The injections restricted vary from desensitization injections to flu injections in ICFs to limits on therapeutic injections. Five States place limits on sterilization services. Twenty States place "other limits" on physicians' services. Examples of "other limits" include coverage excluded for patient-physician telephone contacts, "locked-in" recipients must receive services from one provider except in the case of an emergency, and limits on allergy testing and treatment. The States imposing "other limits" account for 41.0 percent of total Medicaid expenditures for physicians' services.

Table 4.1.8(A)

SUMMARY OF LIMITATIONS ON MANDATORY SERVICES
PHYSICIANS' SERVICES

STATE	No Limits	Specific Services Not Covered	Limits On Injections	Limits On Sterilization Services	Other Limits
ALABAMA	-	-	-	-	X
ALASKA	-	-	-	X	-
ARKANSAS	-	-	X	-	-
CALIFORNIA	-	X	X	-	-
COLORADO	X	-	-	-	-
CONNECTICUT	-	X	-	-	-
DELAWARE	X	-	-	-	-
DIST COLUMBIA	-	X	-	-	-
FLORIDA	-	X	-	-	X
GEORGIA	-	X	X	-	X
HAWAII	-	-	-	-	-
IDAHO	-	X	-	-	-
ILLINOIS	-	-	-	-	X
INDIANA	-	-	-	-	-
IOWA	-	X	X	-	X
KANSAS	-	X	-	-	-
KENTUCKY	-	X	-	-	X
LOUISIANA	-	-	-	-	X
MAINE	X	-	-	-	-
MARYLAND	-	X	-	-	X
MASSACHUSETTS	-	-	-	-	-
MICHIGAN	-	X	-	-	X
MINNESOTA	-	X	-	-	X
MISSISSIPPI	-	X	-	-	-
MISSOURI	-	-	-	-	X
MONTANA	-	X	-	-	X
NEBRASKA	-	-	X	X	-
NEVADA	-	-	X	-	-
NEW HAMPSHIRE	-	-	-	-	X
NEW JERSEY	-	-	-	-	X
NEW MEXICO	-	-	-	-	X
NEW YORK	X	-	-	-	-
N CAROLINA	-	X	-	-	X
N DAKOTA	X	-	-	-	-
OHIO	-	X	-	X	X
OKLAHOMA	-	-	-	-	-
OREGON	-	-	-	-	X
PENNSYLVANIA	-	-	-	-	X
RHODE ISLAND	-	-	-	-	-
S CAROLINA	-	X	-	-	-
S DAKOTA	-	X	-	-	-
TENNESSEE	-	-	-	-	-
TEXAS	X	-	-	-	-
UTAH	-	-	-	X	-
VERMONT	-	X	-	X	-
VIRGINIA	-	X	-	-	-
WASHINGTON	-	X	-	-	X
W VIRGINIA	X	-	-	-	-
WISCONSIN	-	X	-	-	-
WYOMING	-	X	X	-	-
TOTAL STATES	7	23	7	5	20
% TOTAL U.S. $ FOR CATEGORY	15.7	58.6	30.2	5.2	41.0

Table 4.1.8(B) displays limits on frequency of visits for specific settings to include inpatient hospital, long-term care facility, office, home, emergency room, and any setting other than inpatient hospital. The inpatient hospital limits are per inpatient day while visits in other settings are per year. Eleven States limit physician visits in inpatient hospitals per recipient. In general, those limits are one or two physician visits per day for allowable days for which the hospital is paid. If the State additionally has a limit on reimbursable inpatient days, this would affect the total number of physician visits allowed per recipient. Note that New Hampshire limits physician visits to recipients in inpatient hospitals to 12 visits per year. Limits such as these are not necessarily absolute. Such phrases as "prior authorization is required beyond this limit" or "except in emergencies" are frequently attached to the limits. Rhode Island limits physician visits to inpatient hospital patients by provider rather than recipient. A physician in Rhode Island will be reimbursed for a maximum of 37 inpatient visits to Medicaid patients per day.

Limits on frequency of physician visits to long-term care facility recipients have been imposed by 11 States. These limits on visits range from one per month per recipient to three per month per recipient and the States imposing them account for 20.2 percent of total Medicaid expenditures for physicians' services. Rhode Island limits the number of visits per day that a physician can make to six with no limits on the number of visits a recipient can receive.

Limits are placed on number of visits allowed in office settings by six States, in homes by two States, in the emergency room by one State, and in a combination of any settings other than inpatient hospital by seven States.

States also place limits on the number of times a particular service can be provided. A display of these limits is found on Table 4.1.8(C). The specific procedures limited include psychiatric, consultation with specialist, family planning, comprehensive physical examination, hyposensitization, and eye examinations. There are four States that limit frequency of psychiatric visits. Those four States account for 28.7 percent of total Medicaid

Table 4.1.8(B)

SUMMARY OF LIMITATIONS ON MANDATORY SERVICES
PHYSICIANS' SERVICES

	FREQUENCY OF VISITS PER YEAR LIMITED					
	Separate Limits for Specific Settings					
STATE	Inpatient Hospital (per inpatient day)	Long-Term Care Facility	Office	Home	Emergency Room	Any Setting Other Than Inpatient Hosp
ALABAMA	1	-	-	-	-	12
ALASKA	-	-	-	-	-	-
ARKANSAS	2	-	-	-	12	12
CALIFORNIA	-	-	-	-	-	-
COLORADO	-	-	-	-	-	-
CONNECTICUT	-	4	-	-	-	-
DELAWARE	-	-	-	-	-	-
DIST COLUMBIA	-	-	-	-	-	-
FLORIDA	1	12	-	-	-	36
GEORGIA	1	-	12	-	-	-
HAWAII	-	24	-	-	-	-
IDAHO	-	-	-	-	-	-
ILLINOIS	-	-	-	-	-	-
INDIANA	-	-	-	-	-	-
IOWA	-	-	-	-	-	-
KANSAS	1	-	36	12	-	-
KENTUCKY	-	-	-	-	-	-
LOUISIANA	1	-	-	-	-	12
MAINE	-	-	-	-	-	-
MARYLAND	-	-	-	-	-	-
MASSACHUSETTS	-	-	-	-	-	-
MICHIGAN	-	12	-	-	-	-
MINNESOTA	-	-	-	-	-	-
MISSISSIPPI	1	36	-	-	-	18
MISSOURI	-	-	-	-	-	-
MONTANA	-	-	-	-	-	-
NEBRASKA	-	-	-	-	-	-
NEVADA	-	-	24	-	-	-
NEW HAMPSHIRE	-	-	-	-	-	8
NEW JERSEY	-	-	-	-	-	-
NEW MEXICO	2	-	-	-	-	-
NEW YORK	-	-	-	-	-	-
N CAROLINA	-	-	-	-	-	24
N DAKOTA	-	-	-	-	-	-
OHIO	-	36	-	-	-	-
OKLAHOMA	1	24	48	48	-	-
OREGON	-	-	-	-	-	-
PENNSYLVANIA	-	-	-	-	-	-
RHODE ISLAND	-	-	-	-	-	-
S CAROLINA	-	12	18	-	-	-
S DAKOTA	-	-	-	-	-	-
TENNESSEE	1	-	24	-	-	-
TEXAS	-	-	-	-	-	-
UTAH	-	-	-	-	-	-
VERMONT	-	12	-	-	-	-
VIRGINIA	-	-	-	-	-	-
WASHINGTON	1	24	-	-	-	-
W VIRGINIA	-	-	-	-	-	-
WISCONSIN	-	-	-	-	-	-
WYOMING	-	12	-	-	-	-
TOTAL STATES	11	11	6	2	1	7
% TOTAL U.S. $ FOR CATEGORY	17.1	20.2	3.1	2.2	1.2	10.0

Table 4.1.8(C)

SUMMARY OF LIMITATIONS ON MANDATORY SERVICES
PHYSICIANS' SERVICES

STATE	FREQUENCY OF TYPE OF SERVICE PER YEAR LIMITED					
	Psychiatric	Consult with Specialist	Family Planning	Comprehensive Physical Exam	Hyposensitization	Eye Exam
ALABAMA	-	-	-	-	-	-
ALASKA	-	-	-	-	-	-
ARKANSAS	-	-	-	-	-	-
CALIFORNIA	24	-	-	-	24	-
COLORADO	-	-	-	-	-	-
CONNECTICUT	-	-	-	-	-	-
DELAWARE	-	-	-	-	-	-
DIST COLUMBIA	-	-	-	-	-	-
FLORIDA	-	1*	-	-	-	-
GEORGIA	-	-	2	-	-	-
HAWAII	-	-	-	-	-	-
IDAHO	-	-	-	-	-	-
ILLINOIS	-	-	-	-	-	-
INDIANA	-	-	-	-	-	-
IOWA	-	-	-	-	-	-
KANSAS	36	-	-	-	-	-
KENTUCKY	-	-	-	1	-	-
LOUISIANA	-	-	-	-	-	-
MAINE	-	-	-	-	-	-
MARYLAND	-	-	-	-	-	-
MASSACHUSETTS	-	-	-	-	-	-
MICHIGAN	-	-	-	-	-	-
MINNESOTA	-	-	-	-	-	-
MISSISSIPPI	-	-	-	-	-	-
MISSOURI	-	-	-	1	-	-
MONTANA	-	-	-	-	-	1
NEBRASKA	-	-	-	-	-	-
NEVADA	-	-	-	-	-	-
NEW HAMPSHIRE	-	-	-	-	-	-
NEW JERSEY	-	-	-	-	-	-
NEW MEXICO	-	-	-	-	-	-
NEW YORK	-	-	-	-	-	-
N CAROLINA	2	-	-	-	-	1
N DAKOTA	-	-	-	-	-	-
OHIO	-	-	-	-	-	-
OKLAHOMA	-	-	-	-	-	-
OREGON	-	-	-	-	-	-
PENNSYLVANIA	-	-	-	1	-	2
RHODE ISLAND	-	-	-	-	-	-
S CAROLINA	-	3	-	-	-	-
S DAKOTA	-	-	-	-	-	-
TENNESSEE	-	-	-	-	-	-
TEXAS	-	-	-	-	-	-
UTAH	-	-	-	-	-	-
VERMONT	-	-	-	-	-	-
VIRGINIA	26	-	-	-	-	-
WASHINGTON	-	-	-	-	-	-
W VIRGINIA	-	-	-	-	-	-
WISCONSIN	-	-	-	-	-	-
WYOMING	-	-	-	1	-	-
TOTAL STATES	4	2	1	4	1	3
% TOTAL U.S. $ FOR CATEGORY	28.7	3.1	2.6	4.6	24.4	3.5

* Per Specialty Per Illness

expenditures for physicians' services. Two States limit the number of consultations per recipient per year, one State limits family planning visits, four States limit comprehensive physical examinations to one per year, one State limits hyposensitization visits to 24 per year, and three States limit eye examinations.

Table 4.1.8(D) displays types of physician services which require prior authorization. Eighteen States require prior authorization for specific procedures such as hemodialysis, sterilization, obesity surgery, cosmetic surgery and surgical transplants. These 18 States expend 46.2 percent of the total Medicaid dollars for physicians' services. Thirteen States, expending 37.5 percent of total Medicaid dollars for physicians' services, require prior authorization for all elective procedures.

States also require prior authorization according to the setting of the service. Four States name specific settings (e.g., office visits, inpatient hospital) and four other States require prior authorization for care outside of the State. Limits and/or prior authorization for psychiatric services are imposed by 16 States accounting for 50.7 percent of total Medicaid expenditures for physicians' services. Examples of limits/prior authorization include specific dollar limits on psychiatric services and prior authorization beyond initial evaluations.

4.1.9 Home Health Services

Home health services are provided to a recipient at his place of residence which does not include a hospital, skilled nursing facility, or intermediate care facility (ICF) except for home health services in an ICF that are not required to be provided by the facility. Services provided must be on physician's orders as part of a written plan of care that is reviewed by the physician every 60 days. Home health services include three mandatory services (part-time nursing, home health aide, and medical supplies and equipment) and one optional service (physical therapy, occupational therapy, and speech pathology and audiology services) (42 CFR 440.70). These services are defined as follows:

Table 4.1.8(D)

SUMMARY OF LIMITATIONS ON MANDATORY SERVICES
PHYSICIANS' SERVICES

STATE	Prior Authorization Required For: Specific Procedures	Elective Procedures	Specific Settings	Care Outside State	Limits Or Prior Authorization Required For Psychiatric Services
ALABAMA	-	-	-	X	-
ALASKA	X	X	-	-	-
ARKANSAS	-	X	-	-	-
CALIFORNIA	X	X	-	-	X
COLORADO	-	-	-	-	-
CONNECTICUT	-	-	-	-	X
DELAWARE	-	-	-	-	-
DIST COLUMBIA	-	X	-	-	X
FLORIDA	-	X	-	-	-
GEORGIA	X	X	X	-	-
HAWAII	-	-	-	-	-
IDAHO	-	-	-	X	X
ILLINOIS	-	-	-	-	-
INDIANA	X	-	-	-	-
IOWA	X	-	-	-	-
KANSAS	X	-	-	X	X
KENTUCKY	-	-	-	-	X
LOUISIANA	X	-	-	-	-
MAINE	-	-	-	-	-
MARYLAND	X	-	-	-	-
MASSACHUSETTS	-	X	-	-	-
MICHIGAN	-	-	-	-	X
MINNESOTA	X	-	-	-	-
MISSISSIPPI	-	-	-	-	-
MISSOURI	-	X	-	-	X
MONTANA	X	-	-	-	-
NEBRASKA	-	-	-	-	X
NEVADA	-	-	-	-	-
NEW HAMPSHIRE	-	-	X	-	-
NEW JERSEY	X	-	-	-	X
NEW MEXICO	-	-	-	-	-
NEW YORK	-	-	-	-	-
N CAROLINA	X	-	-	-	X
N DAKOTA	-	-	-	-	-
OHIO	-	-	X	-	-
OKLAHOMA	-	-	-	-	-
OREGON	-	X	-	X	-
PENNSYLVANIA	-	-	-	-	-
RHODE ISLAND	X	X	X	-	X
S CAROLINA	-	-	-	-	-
S DAKOTA	-	-	-	-	-
TENNESSEE	X	-	-	-	-
TEXAS	-	-	-	-	X
UTAH	X	X	-	-	-
VERMONT	X	X	-	-	X
VIRGINIA	X	-	-	-	X
WASHINGTON	-	X	-	-	X
W VIRGINIA	-	-	-	-	-
WISCONSIN	X	-	-	-	-
WYOMING	-	-	-	-	-
TOTAL STATES	18	13	4	4	16
% TOTAL U.S. $ FOR CATEGORY	46.2	37.5	7.0	3.6	50.7

- Part-time Nursing - Nursing service that is provided on a part-time or intermittent basis by a home health agency. If there is no home health agency in the area, services may be provided by a registered nurse who is currently licensed to practice in the State, receives written orders from the patient's physician, documents the care and services provided, and has had orientation to acceptable clinical and administrative record-keeping from a health department nurse;

- Home Health Aide - Home health aide service that is provided by a home health agency;

- Medical supplies and Equipment - Medical supplies, equipment and appliances that are suitable for use in the home; and

- Physical Therapy (PT), Occupational Therapy (OT), and Speech Pathology and Audiology Services - PT, OT, and speech and hearing services provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services.

Home health services are provided to categorically needy recipients age 21 and over and to those under 21 only if the State plan provides SNF services for them.

Part-time nursing services, Table 4.1.9(A), have no limitations placed upon them by 17 States which account for 6.8 percent of total Medicaid expenditures for home health. Thirteen States require prior authorization for nursing services. Of this group, New York alone expends more than 75 percent of the total Medicaid expenditures for home health. Fifteen States have limits on visits and 13 States have "other limits."

Home health aide services are provided without limitations by 16 States which account for 6.3 percent of total Medicaid expenditures for home health services (Table 4.1.9(B)). Twelve States accounting for 83.2 percent of total Medicaid expenditures for home health require prior authorization for home health aide services. Sixteen States have limitations on number of visits and/or hours representing 5.4 percent total home health expenditures; homemaker services are not provided by five States with 2.3 percent total home health expenditures and "other limits" are placed by nine States, accounting for 5.6 percent total home health expenditures.

Table 4.1.9(A)

SUMMARY OF LIMITATIONS ON MANDATORY SERVICES
HOME HEALTH SERVICES: PART-TIME NURSING

STATE	No Limits	Prior Authorization Required	Limits On Visits	Other Limits
ALABAMA	-	X	X	-
ALASKA	-	X	-	-
ARKANSAS	X	-	-	-
CALIFORNIA	-	X	-	-
COLORADO	-	X	-	-
CONNECTICUT	-	-	-	X
DELAWARE	X	-	-	-
DIST COLUMBIA	X	-	-	-
FLORIDA	X	-	-	-
GEORGIA	-	-	X	-
HAWAII	X	-	-	-
IDAHO	-	-	X	-
ILLINOIS	-	X	-	-
INDIANA	-	X	-	-
IOWA	X	-	-	-
KANSAS	-	-	-	X
KENTUCKY	-	-	-	X
LOUISIANA	-	-	X	X
MAINE	X	-	-	-
MARYLAND	-	-	-	X
MASSACHUSETTS	-	-	-	X
MICHIGAN	X	-	-	-
MINNESOTA	X	-	-	-
MISSISSIPPI	-	-	X	X
MISSOURI	-	-	X	X
MONTANA	-	-	X	-
NEBRASKA	X	-	-	-
NEVADA	-	X	-	-
NEW HAMPSHIRE	-	-	X	-
NEW JERSEY	-	X	-	-
NEW MEXICO	-	X	-	X
NEW YORK	-	X	-	-
N CAROLINA	-	-	-	X
N DAKOTA	X	-	-	-
OHIO	X	-	-	-
OKLAHOMA	-	-	X	-
OREGON	-	X	-	-
PENNSYLVANIA	-	-	X	-
RHODE ISLAND	-	X	X	-
S CAROLINA	-	-	X	X
S DAKOTA	-	-	X	-
TENNESSEE	-	-	X	-
TEXAS	-	X	X	-
UTAH	X	-	-	-
VERMONT	X	-	-	-
VIRGINIA	X	-	-	-
WASHINGTON	-	-	-	X
W VIRGINIA	X	-	-	-
WISCONSIN	X	-	-	-
WYOMING	-	-	-	X
TOTAL STATES	17	13	15	13
% TOTAL U.S. $ FOR CATEGORY	6.8	83.6	4.0	7.3

Table 4.1.9(B)

SUMMARY OF LIMITATIONS ON MANDATORY SERVICES
HOME HEALTH SERVICES: AIDE SERVICES

STATE	No Limits	Prior Authorization Required	Limits On Visits and/or Hours	Homemaker Services Not Provided	Other Limits
ALABAMA	-	X	X	-	-
ALASKA	-	X	-	-	-
ARKANSAS	X	-	-	-	-
CALIFORNIA	-	X	X	-	-
COLORADO	-	X	-	-	-
CONNECTICUT	-	-	X	-	-
DELAWARE	X	-	-	-	-
DIST COLUMBIA	X	-	-	-	-
FLORIDA	X	-	-	-	-
GEORGIA	-	-	X	-	-
HAWAII	X	-	-	-	-
IDAHO	-	-	X	-	-
ILLINOIS	-	X	-	-	-
INDIANA	-	-	-	X	-
IOWA	X	-	-	-	-
KANSAS	-	-	-	X	-
KENTUCKY	-	-	-	X	-
LOUISIANA	-	-	X	-	X
MAINE	X	-	-	-	-
MARYLAND	-	-	-	-	X
MASSACHUSETTS	-	-	-	-	X
MICHIGAN	X	-	-	-	-
MINNESOTA	X	-	-	-	-
MISSISSIPPI	-	-	X	-	X
MISSOURI	-	-	X	-	-
MONTANA	-	-	X	-	-
NEBRASKA	-	-	-	-	X
NEVADA	-	X	-	-	-
NEW HAMPSHIRE	-	-	X	-	-
NEW JERSEY	-	X	-	-	-
NEW MEXICO	-	X	-	-	X
NEW YORK	-	X	-	-	-
N CAROLINA	-	-	-	-	X
N DAKOTA	X	-	-	-	-
OHIO	X	-	-	-	-
OKLAHOMA	-	-	X	-	-
OREGON	-	X	-	-	-
PENNSYLVANIA	-	-	X	-	-
RHODE ISLAND	-	X	X	-	-
S CAROLINA	-	-	-	X	-
S DAKOTA	-	-	X	-	-
TENNESSEE	-	-	X	-	-
TEXAS	-	X	X	-	-
UTAH	X	-	-	-	-
VERMONT	-	-	-	-	X
VIRGINIA	X	-	-	-	-
WASHINGTON	-	-	-	X	X
W VIRGINIA	X	-	-	-	-
WISCONSIN	X	-	-	-	-
WYOMING	X	-	-	-	-
TOTAL STATES	16	12	16	5	9
% TOTAL U.S. $ FOR CATEGORY	6.3	83.2	5.4	2.3	5.6

Limitations on medical supplies and equipment are found on Table 4.1.9(C). Only five States, accounting for less than two percent of total home health expenditures, have no limits on medical supplies and equipment. Prior authorization is required by 29 States and those 29 States account for 89.9 percent of total Medicaid expenditures for home health services. Additionally, States place limits on quantity/dollars, restrict supply lists, and/or place "other limits" on medical supplies and equipment. "Other limits" include limits on luxury models of equipment, services provided by out-of-state agencies, delivery of equipment, and home oxygen supplies. These 19 States expend only 8.7 percent of total Medicaid expenditures for Home Health Services.

The fourth category of home health services (Table 4.1.9(D)), physical therapy (PT), occupational therapy (OT), and speech and hearing services, is actually an optional service and four States expending approximately one percent of the total expenditures on home health services do not provide the service. Of the remaining 46 States, eight place no limits on these services. These eight States account for only 2.2 percent of total Medicaid expenditures for home health services while the 16 States which require prior authorization for PT, OT, and Speech and Hearing services account for 86.0 percent of total home health expenditures. Twelve States place limits on visits and 18 States place limits on services. Fourteen States place "other limits" on PT, OT, and speech and hearing services such as intermittent or part-time services only, services for homebound patients only, and services provided by certified practitioners only.

4.1.10 Nurse-Midwife Services

The Omnibus Reconciliation Act of 1980 mandates that payment must be made for nurse-midwife services to categorically needy recipients (42 CFR 440.165). The effective date of this legislation was July 16, 1982, or, if State legislation was needed in order to conform, the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that began after May 17, 1982.

Table 4.1.9(C)

SUMMARY OF LIMITATIONS ON MANDATORY SERVICES
HOME HEALTH SERVICES: MEDICAL SUPPLIES/EQUIPMENT

STATE	No Limits	Prior Authorization Required	Limits On Quantity or Dollars	Restricted Supply List	Other Limits
ALABAMA	-	-	-	X	-
ALASKA	-	X	-	-	-
ARKANSAS	X	-	-	-	-
CALIFORNIA	-	X	-	-	-
COLORADO	-	X	-	-	-
CONNECTICUT	X	-	-	-	-
DELAWARE	X	-	-	-	-
DIST COLUMBIA	-	X	-	X	-
FLORIDA	-	-	X	X	-
GEORGIA	-	X	-	X	-
HAWAII	-	X	-	-	-
IDAHO	-	X	X	-	X
ILLINOIS	-	X	-	-	-
INDIANA	-	X	-	-	-
IOWA	-	-	-	-	X
KANSAS	-	X	-	-	X
KENTUCKY	-	X	-	-	-
LOUISIANA	-	X	-	-	-
MAINE	X	-	-	-	-
MARYLAND	-	-	-	-	X
MASSACHUSETTS	-	-	-	-	X
MICHIGAN	-	-	-	-	X
MINNESOTA	-	X	-	-	X
MISSISSIPPI	-	-	X	-	-
MISSOURI	-	-	-	-	X
MONTANA	-	X	-	-	X
NEBRASKA	-	X	X	-	-
NEVADA	-	X	-	-	-
NEW HAMPSHIRE	-	X	-	-	-
NEW JERSEY	-	X	-	-	-
NEW MEXICO	-	X	-	-	-
NEW YORK	-	X	-	-	-
N CAROLINA	-	-	-	-	X
N DAKOTA	X	-	-	-	-
OHIO	-	-	-	-	X
OKLAHOMA	-	-	-	-	X
OREGON	-	X	-	-	-
PENNSYLVANIA	-	X	-	-	-
RHODE ISLAND	-	X	-	-	-
S CAROLINA	-	X	-	X	-
S DAKOTA	-	-	-	-	X
TENNESSEE	-	-	-	-	X
TEXAS	-	X	-	-	X
UTAH	-	X	-	-	X
VERMONT	-	-	-	-	X
VIRGINIA	-	X	-	X	-
WASHINGTON	-	X	-	-	-
W VIRGINIA	-	X	-	-	-
WISCONSIN	-	-	-	-	X
WYOMING	-	-	-	-	X
TOTAL STATES	5	29	4	6	19
% TOTAL U.S. $ FOR CATEGORY	1.5	89.9	1.1	4.0	8.7

Table 4.1.9(D)

SUMMARY OF LIMITATIONS ON MANDATORY SERVICES
HOME HEALTH SERVICES: PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH AND HEARING

STATE	Not Provided	No Limits	Prior Authorization Required	Limits On Visits	Limits On Services	Other Limits
ALABAMA	X	-	-	-	-	-
ALASKA	-	-	X	-	-	-
ARKANSAS	-	-	-	-	X	-
CALIFORNIA	-	-	X	X	-	-
COLORADO	-	-	X	-	-	-
CONNECTICUT	-	X	-	-	-	-
DELAWARE	-	X	-	-	-	-
DIST COLUMBIA	-	-	-	-	-	X
FLORIDA	X	-	-	-	-	-
GEORGIA	-	-	X	X	-	X
HAWAII	-	X	-	-	-	-
IDAHO	-	-	-	-	X	-
ILLINOIS	-	-	X	-	-	-
INDIANA	-	-	X	-	X	-
IOWA	-	-	-	-	X	-
KANSAS	-	-	-	-	X	X
KENTUCKY	-	-	-	-	X	-
LOUISIANA	-	-	-	-	X	X
MAINE	-	X	-	-	-	-
MARYLAND	-	-	-	X	X	X
MASSACHUSETTS	-	-	-	-	-	X
MICHIGAN	-	-	-	-	X	-
MINNESOTA	-	-	-	-	-	X
MISSISSIPPI	-	-	-	X	X	-
MISSOURI	-	-	-	-	X	-
MONTANA	-	-	-	X	X	-
NEBRASKA	-	X	-	-	-	-
NEVADA	-	-	X	-	-	-
NEW HAMPSHIRE	-	-	-	X	X	-
NEW JERSEY	-	-	X	-	-	-
NEW MEXICO	-	-	X	-	-	X
NEW YORK	-	-	X	-	-	-
N CAROLINA	-	-	-	-	X	-
N DAKOTA	-	X	-	-	-	-
OHIO	-	-	X	X	X	-
OKLAHOMA	X	-	-	-	-	-
OREGON	-	-	X	-	X	-
PENNSYLVANIA	X	-	-	-	-	-
RHODE ISLAND	-	-	X	X	-	-
S CAROLINA	-	-	-	-	X	X
S DAKOTA	-	-	-	X	-	-
TENNESSEE	-	-	-	X	-	X
TEXAS	X	-	-	-	-	-
UTAH	-	-	X	X	X	-
VERMONT	-	-	-	-	-	X
VIRGINIA	-	X	-	-	-	-
WASHINGTON	-	-	X	-	-	X
W VIRGINIA	-	X	-	-	-	-
WISCONSIN	-	-	X	X	-	X
WYOMING	-	-	-	-	-	X
TOTAL STATES	5	8	16	12	18	14
% TOTAL U.S. $ FOR CATEGORY	1.9	2.2	86.0	5.0	5.4	9.3

These provisions require States to provide coverage for nurse-midwife services to the extent that the nurse-midwife is authorized to practice under State law or regulation. The statute also requires that States offer direct reimbursement to nurse-midwives as one of the payment options. Nurse-midwives must be registered nurses who are either certified by an organization recognized by the Secretary or have completed a program of study and clinical experience that has been approved by the Secretary. Nurse-midwife services are those concerned with management of the care of mothers and newborns throughout the maternity cycle.

Table 4.1.10 shows that as of March 1983, 25 States still did not provide nurse-midwife services. This table also shows that nine States provided the services with no limits and 16 States provided the services with "other limits." The 16 States accounted for 45.6 percent of total Medicaid expenditures for other practitioners. These "other limits" include supervision by a physician required, provided only when the nurse-midwife is employed by a hospital or physician, and limited to certified facilities.

4.2 LIMITATIONS ON OPTIONAL SERVICES

Tables 4.2.1 through 4.2.11 display limitations on optional services for the categorically needy by service. The general descriptive information and caveats pertaining to the Tables on mandatory services are also applicable to these tables.

4.2.1 Intermediate Care Facility Services and Intermediate Care Facility Services for the Mentally Retarded

Intermediate care facility (ICF) services, other than in an institution for tuberculosis or mental diseases, means services provided in a facility that fully meets the requirements for a State license to provide, on a regular basis, health related services to individuals who do not require hospital or SNF care but whose mental or physical condition requires services that are above the level of room and board and can be made available only through institutional facilities. The facility must meet all the requirements to be certified for Medicaid (42 CFR 440.150(a-b)).

Table 4.1.10

SUMMARY OF LIMITATIONS ON MANDATORY SERVICES
NURSE-MIDWIFE SERVICES

STATE	Not Provided	No Limits	Other Limits
ALABAMA	-	-	X
ALASKA	-	X	-
ARKANSAS	X	-	-
CALIFORNIA	-	-	X
COLORADO	-	X	-
CONNECTICUT	X	-	-
DELAWARE	-	-	X
DIST COLUMBIA	X	-	-
FLORIDA	-	-	X
GEORGIA	-	-	X
HAWAII	-	-	X
IDAHO	-	X	-
ILLINOIS	X	-	-
INDIANA	-	-	X
IOWA	X	-	-
KANSAS	X	-	-
KENTUCKY	X	-	-
LOUISIANA	X	-	-
MAINE	-	-	X
MARYLAND	-	-	X
MASSACHUSETTS	-	-	X
MICHIGAN	X	-	-
MINNESOTA	-	X	-
MISSISSIPPI	-	-	X
MISSOURI	X	-	-
MONTANA	-	X	-
NEBRASKA	X	-	-
NEVADA	X	-	-
NEW HAMPSHIRE	-	-	X
NEW JERSEY	-	-	X
NEW MEXICO	X	-	-
NEW YORK	X	-	-
N CAROLINA	X	-	-
N DAKOTA	X	-	-
OHIO	X	-	-
OKLAHOMA	X	-	-
OREGON	-	-	X
PENNSYLVANIA	-	-	X
RHODE ISLAND	-	X	-
S CAROLINA	X	-	-
S DAKOTA	X	-	-
TENNESSEE	X	-	-
TEXAS	X	-	-
UTAH	X	-	-
VERMONT	-	X	-
VIRGINIA	X	-	-
WASHINGTON	-	-	X
W VIRGINIA	-	X	-
WISCONSIN	-	X	-
WYOMING	X	-	-
TOTAL STATES	25	9	16
% TOTAL U.S. $ FOR CATEGORY	37.1	17.2	45.6

Limitations on intermediate care facilities (ICFs) other than in institutions for tuberculosis or mental diseases, are displayed on the left hand side of Table 4.2.1. This optional service is provided by all 50 jurisdictions; 21 of those jurisdictions, which make up 34.6 percent of total expenditures for ICF services, place no limits on ICF services. Nineteen States require prior authorization for ICF services. These 19 States expend 39.5 percent of the total Medicaid dollars spent on ICF services and four of them require further that periodic reauthorization be made. "Other limits" are placed on ICF services by 13 States which account for 39.7 percent of the total Medicaid expenditures for ICF services. Examples of "other limits" include limits on specific services (e.g., OT, PT, speech), on bed reservations for hospitalized recipients, on administrative days, and on services by out-of-State long-term care facilities.

The right-hand side of Table 4.2.1 displays limitations on intermediate care facilities for the mentally retarded. ICF services may include services provided in an institution for the mentally retarded or persons with related conditions if (42 CFR 440.150(c-e):

- The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions;
- The institution meets the requirements that an ICF must meet to obtain certification from the State; and
- The mentally retarded recipient for whom payment is requested is receiving active treatment as defined in 42 CFR 435.1009.

This optional service is provided by 49 jurisdictions with Wyoming the only State not providing ICF-MR services.

Twenty-four States, accounting for 46.7 percent of the total Medicaid expenditures for ICF-MR services, placed no limits on ICF-MR services. Seventeen States require prior authorization and three of the 17 States require periodic reauthorization. Eight States place "other limits" on ICF-MR services. These "other limits" include such items as limiting services to instate facilities, specifying the professional staff that will determine the certification of need and level of placement and the time period within which level of care must be determined.

Table 4.2.1

SUMMARY OF LIMITATIONS ON OPTIONAL SERVICES

STATE	INTERMEDIATE CARE FACILITY SERVICES					INTERMEDIATE CARE FACILITY SERVICES FOR MENTALLY RETARDED				
	Not Provided	No Limits	Prior Authorization Required	Periodic Reauthorization	Other Limits	Not Provided	No Limits	Prior Authorization Required	Periodic Reauthorization	Other Limits
ALABAMA	-	-	X	-	-	-	-	X	-	-
ALASKA	-	-	X	-	-	-	-	X	-	-
ARKANSAS	-	-	X	-	-	-	-	X	-	-
CALIFORNIA	-	-	X	X	-	-	-	X	X	-
COLORADO	-	-	X	X	-	-	-	X	X	-
CONNECTICUT	-	X	-	-	-	-	X	-	-	-
DELAWARE	-	X	-	-	-	-	X	-	-	-
DIST COLUMBIA	-	X	-	-	-	-	X	-	-	-
FLORIDA	-	X	-	-	-	-	X	-	-	-
GEORGIA	-	-	X	-	-	-	-	X	-	-
HAWAII	-	-	X	-	-	-	-	X	-	-
IDAHO	-	X	-	-	-	-	X	-	-	-
ILLINOIS	-	X	-	-	-	-	X	-	-	-
INDIANA	-	-	-	-	X	-	-	-	-	X
IOWA	-	X	-	-	-	-	X	-	-	-
KANSAS	-	-	-	-	X	-	-	-	-	X
KENTUCKY	-	-	X	-	-	-	-	X	-	-
LOUISIANA	-	X	-	-	-	-	X	-	-	-
MAINE	-	X	-	-	-	-	X	-	-	-
MARYLAND	-	-	X	-	X	-	X	-	-	-
MASSACHUSETTS	-	-	-	-	X	-	X	-	-	-
MICHIGAN	-	-	X	-	X	-	X	-	-	-
MINNESOTA	-	X	-	-	-	-	X	-	-	-
MISSISSIPPI	-	-	X	-	-	-	-	X	-	-
MISSOURI	-	X	-	-	-	-	X	-	-	-
MONTANA	-	X	-	-	-	-	X	-	-	-
NEBRASKA	-	-	-	-	X	-	-	-	-	X
NEVADA	-	-	X	-	-	-	-	X	-	-
NEW HAMPSHIRE	-	-	X	X	-	-	-	X	X	-
NEW JERSEY	-	-	X	X	-	-	-	-	-	X
NEW MEXICO	-	X	-	-	-	-	X	-	-	-
NEW YORK	-	-	X	-	X	-	-	X	-	-
N CAROLINA	-	-	X	-	-	-	-	X	-	-
N DAKOTA	-	X	-	-	-	-	X	-	-	-
OHIO	-	X	-	-	-	-	X	-	-	-
OKLAHOMA	-	-	X	-	-	-	-	X	-	-
ORIGON	-	-	-	-	X	-	-	X	-	-
PENNSYLVANIA	-	X	-	-	-	-	X	-	-	-
RHODE ISLAND	-	-	X	-	-	-	-	X	-	-
S CAROLINA	-	-	X	-	-	-	-	X	-	-
S OAKOTA	-	X	-	-	-	-	-	-	-	X
TENNESSEE	-	-	-	-	X	-	X	-	-	-
TEXAS	-	-	-	-	X	-	-	-	-	X
UTAH	-	X	-	-	-	-	X	-	-	-
VERMONT	-	-	-	-	X	-	X	-	-	-
VIRGINIA	-	X	-	-	-	-	X	-	-	-
WASHINGTON	-	X	-	-	-	-	X	-	-	-
W VIRGINIA	-	-	-	-	X	-	-	-	-	X
WISCONSIN	-	-	-	-	X	-	-	-	-	X
WYOMING	-	X	-	-	-	X	-	-	-	-
TOTAL STATES	0	21	19	4	13	1	24	17	3	8
% TOTAL U S FOR CATEGORY	0.0	34.6	39.5	7.5	39.7	0.0	46.7	38.4	2.5	14.9

4.2.2 Services for Individuals Age 65 or Older in Institutions for Tuberculosis

A State may choose to provide any of three levels of care for inpatient services to individuals age 65 or older in institutions for tuberculosis (42 CFR 440.140). Those levels of care are inpatient hospital, skilled nursing facilities, and intermediate care facilities. Inpatient hospital services for individuals age 65 or older in institutions for tuberculosis means services provided under the direction of a physician for the care and treatment of recipients in an institution for tuberculosis that meets the requirements under Medicare. The institution is primarily engaged in providing diagnosis, treatment, or care of individuals with tuberculosis, including medical attention, nursing care, and related services. Table 4.2.2 shows that 31 States, accounting for 55.8 percent of the total Medicaid expenditures for all services, do not provide inpatient hospital services for individuals age 65 and older in TB institutions. Thirteen States provide the service with no limitations, three States require prior authorization and five States have "other limits." "Other limits" include limited to services in State institution and must be certified as medically necessary by the attending physician in the TB institution.

Skilled nursing facility services for individuals age 65 or older in institutions for tuberculosis means SNF services, as defined for other Medicaid recipients, that are provided in institutions for tuberculosis. Forty-four States do not provide SNF services to individuals age 65 and older in TB institutions. These 44 States account for 77.1 percent of the total Medicaid expenditures for all services. Five States provide SNF services with no limitations, one State requires prior authorization, and one State has "other limits."

Intermediate care facility services for individuals age 65 or older in institutions for tuberculosis means ICF services as defined for Medicaid recipients that are provided to recipients who are determined to be in need of services in institutions for tuberculosis. Forty-four States do not provide ICF services for individuals age 65 or older in institutions for tuberculosis. Those 44 States expend 77.1 percent of total Medicaid dollars for all

Table 4.2.2

SUMMARY OF LIMITATIONS ON OPTIONAL SERVICES
SERVICES FOR INDIVIDUALS 65+ IN TB INSTITUTIONS

STATE	INPATIENT HOSPITAL				SKILLED NURSING FACILITIES				INTERMEDIATE CARE FACILITIES			
	Not Provided	No Limits	Prior Authorization Required	Other Limits	Not Provided	No Limits	Prior Authorization Required	Other Limits	Not Provided	No Limits	Prior Authorization Required	Other Limits
ALABAMA	-	-	X	X	X	-	-	-	X	-	-	-
ALASKA	X	-	-	-	X	-	-	-	X	-	-	-
ARKANSAS	-	X	-	-	-	X	-	-	-	X	-	-
CALIFORNIA	-	-	X	X	-	-	X	X	-	-	X	X
COLORADO	X	-	-	-	X	-	-	-	X	-	-	-
CONNECTICUT	X	-	-	-	X	-	-	-	X	-	-	-
DELAWARE	X	-	-	-	X	-	-	-	X	-	-	-
DIST COLUMBIA	-	-	-	X	X	-	-	-	X	-	-	-
FLORIDA	-	X	-	-	X	-	-	-	X	-	-	-
GEORGIA	X	-	-	-	X	-	-	-	X	-	-	-
HAWAII	X	-	-	-	X	-	-	-	X	-	-	-
IDAHO	X	-	-	-	X	-	-	-	X	-	-	-
ILLINOIS	-	X	-	-	-	X	-	-	-	X	-	-
INDIANA	X	-	-	-	X	-	-	-	X	-	-	-
IOWA	X	-	-	-	X	-	-	-	X	-	-	-
KANSAS	X	-	-	-	X	-	-	-	X	-	-	-
KENTUCKY	-	X	-	-	X	-	-	-	X	-	-	-
LOUISIANA	-	X	-	-	X	-	-	-	X	-	-	-
MAINE	X	-	-	-	X	-	-	-	X	-	-	-
MARYLAND	-	X	-	-	X	-	-	-	X	-	-	-
MASSACHUSETTS	X	-	-	-	X	-	-	-	X	-	-	-
MICHIGAN	X	-	-	-	X	-	-	-	X	-	-	-
MINNESOTA	-	X	-	-	-	X	-	-	-	X	-	-
MISSISSIPPI	-	X	-	-	X	-	-	-	X	-	-	-
MISSOURI	-	-	-	X	X	-	-	-	X	-	-	-
MONTANA	X	-	-	-	X	-	-	-	X	-	-	-
NEBRASKA	X	-	-	-	X	-	-	-	X	-	-	-
NEVADA	X	-	-	-	X	-	-	-	X	-	-	-
NEW HAMPSHIRE	X	-	-	-	X	-	-	-	X	-	-	-
NEW JERSEY	-	-	-	X	X	-	-	-	X	-	-	-
NEW MEXICO	X	-	-	-	X	-	-	-	X	-	-	-
NEW YORK	X	-	-	-	X	-	-	-	X	-	-	-
N CAROLINA	-	X	-	-	X	-	-	-	X	-	-	-
N DAKOTA	X	-	-	-	X	-	-	-	X	-	-	-
OHIO	X	-	-	-	X	-	-	-	X	-	-	-
OKLAHOMA	X	-	-	-	X	-	-	-	X	-	-	-
OREGON	X	-	-	-	X	-	-	-	X	-	-	-
PENNSYLVANIA	X	-	-	-	X	-	-	-	X	-	-	-
RHODE ISLAND	X	-	-	-	X	-	-	-	X	-	-	-
S CAROLINA	-	-	X	-	X	-	-	-	X	-	-	-
S DAKOTA	X	-	-	-	X	-	-	-	X	-	-	-
TENNESSEE	-	X	-	-	-	X	-	-	-	X	-	-
TEXAS	-	X	-	-	X	-	-	-	X	-	-	-
UTAH	X	-	-	-	X	-	-	-	X	-	-	-
VERMONT	X	-	-	-	X	-	-	-	X	-	-	-
VIRGINIA	-	X	-	-	X	-	-	-	X	-	-	-
WASHINGTON	-	X	-	-	-	X	-	-	-	X	-	-
W VIRGINIA	X	-	-	-	X	-	-	-	X	-	-	-
WISCONSIN	X	-	-	-	X	-	-	-	X	-	-	-
WYOMING	X	-	-	-	X	-	-	-	X	-	-	-
TOTAL STATES	31	13	3	5	44	5	1	1	44	5	1	1
% TOTAL U.S. $ FOR CATEGORY	55.8	25.4	13.9	17.8	77.1	11.1	11.9	11.9	77.1	11.1	11.9	11.9

services. Five States provide ICF services with no limitations, one State requires prior authorization for ICF services, and one State has "other limits."

4.2.3 Services for Individuals Age 65 and Older in Institutions for Mental Diseases

A State may choose to provide services of any of three levels of care for individuals age 65 or older in institutions for mental diseases (42 CFR 440.140). These services include inpatient hospital services, SNF services, and ICF services. An institution for mental diseases is defined to be one that meets the requirements under Medicare except the requirements for admission reviews and utilization review if the institution has been granted a waiver of UR plan requirements. Services provided are diagnosis, treatment, and care of individuals with mental diseases including medical care, nursing care, and related services. Limitations on these services are displayed on Table 4.2.3.

Inpatient hospital services for individuals age 65 or older in institutions for mental diseases mean services provided under the direction of a physician for the care and treatment of recipients in an institution for mental diseases. Nine States do not provide inpatient hospital services for individuals age 65 or older in institutions for mental diseases. Twenty-five States, accounting for 32.1 percent of total Medicaid expenditures for mental health inpatient services, provide inpatient hospital services with no limitations. Three States require prior authorization and 14 States place "other limits" on inpatient hospital services for individuals age 65 or older in institutions for mental diseases. The "other limits" include limits on days in approved private institutions, services must be provided in State institutions and services limited to those recipients who are not eligible for and/or have exhausted their Title XVIII benefits.

Skilled nursing facility services for individuals age 65 or older in institutions for mental diseases means SNF services that are provided in institutions for mental diseases. SNF services are not provided in 28 States. Eleven States provide SNF services for the aged without limits and expend 23.4 percent of the total Medicaid dollars spent for SNF/ICF mental health services for the aged. Eight States require prior authorization and

Table 4.2.3

SUMMARY OF LIMITATIONS ON OPTIONAL SERVICES
SERVICES FOR INDIVIDUALS 65+ IN MENTAL INSTITUTIONS

STATE	INPATIENT HOSPITAL				SKILLED NURSING FACILITIES				INTERMEDIATE CARE FACILITIES			
	Not Provided	No Limits	Prior Authorization Required	Other Limits	Not Provided	No Limits	Prior Authorization Required	Other Limits	Not Provided	No Limits	Prior Authorization Required	Other Limits
ALABAMA	X	-	-	-	-	-	X	-	-	-	X	-
ALASKA	-	-	X	-	X	-	-	-	X	-	-	-
ARKANSAS	-	-	-	X	-	-	X	-	-	-	X	-
CALIFORNIA	-	-	X	X	-	-	X	X	-	-	X	X
COLORADO	-	X	-	-	-	-	X	-	-	-	X	-
CONNECTICUT	-	X	-	-	X	-	-	-	X	-	-	-
DELAWARE	-	X	-	-	X	-	-	-	-	X	-	-
DIST COLUMBIA	-	-	-	X	-	-	-	X	-	-	-	X
FLORIDA	-	-	-	X	X	-	-	-	X	-	-	-
GEORGIA	X	-	-	-	X	-	-	-	X	-	-	-
HAWAII	X	-	-	-	X	-	-	-	X	-	-	-
IDAHO	X	-	-	-	X	-	-	-	-	X	-	-
ILLINOIS	-	X	-	-	-	X	-	-	-	X	-	-
INDIANA	-	X	-	-	X	-	-	-	X	-	-	-
IOWA	-	X	-	-	X	-	-	-	X	-	-	-
KANSAS	-	X	-	-	X	-	-	-	-	-	-	X
KENTUCKY	-	X	-	-	-	-	X	X	-	-	X	X
LOUISIANA	-	-	-	X	-	X	-	-	-	X	-	-
MAINE	-	X	-	-	-	X	-	-	-	X	-	-
MARYLAND	-	X	-	-	X	-	-	-	-	X	-	-
MASSACHUSETTS	-	X	-	-	-	X	-	-	-	X	-	-
MICHIGAN	-	-	-	X	-	-	X	X	-	-	X	X
MINNESOTA	-	X	-	-	-	X	-	-	-	X	-	-
MISSISSIPPI	X	-	-	-	X	-	-	-	X	-	-	-
MISSOURI	-	-	-	X	X	-	-	-	X	-	-	-
MONTANA	-	X	-	-	-	X	-	-	-	X	-	-
NEBRASKA	-	X	-	-	-	X	-	-	-	X	-	-
NEVADA	-	-	-	X	-	-	X	-	-	-	X	-
NEW HAMPSHIRE	-	X	-	-	X	-	-	-	-	-	X	X
NEW JERSEY	-	-	-	X	-	-	X	-	-	-	X	-
NEW MEXICO	X	-	-	-	X	-	-	-	X	-	-	-
NEW YORK	-	-	-	X	X	-	-	-	X	-	-	-
N CAROLINA	-	X	-	-	X	-	-	-	X	-	-	-
N DAKOTA	-	X	-	-	X	-	-	-	X	-	-	-
OHIO	-	-	-	X	-	-	-	X	-	-	-	X
OKLAHOMA	-	-	-	X	X	-	-	-	X	-	-	-
OREGON	-	X	-	-	X	-	-	-	X	-	-	-
PENNSYLVANIA	-	-	-	X	-	X	-	-	-	X	-	-
RHODE ISLAND	-	X	-	-	X	-	-	-	X	-	-	-
S CAROLINA	-	-	X	-	X	-	-	-	X	-	-	-
S DAKOTA	-	-	-	X	-	-	-	X	-	-	-	X
TENNESSEE	-	X	-	-	-	X	-	-	-	X	-	-
TEXAS	X	-	-	-	X	-	-	-	X	-	-	-
UTAH	-	X	-	-	-	X	-	-	-	X	-	-
VERMONT	-	X	-	-	X	-	-	-	X	-	-	-
VIRGINIA	-	X	-	-	X	-	-	-	X	-	-	-
WASHINGTON	-	X	-	-	-	X	-	-	-	X	-	-
W VIRGINIA	X	-	-	-	X	-	-	-	X	-	-	-
WISCONSIN	-	X	-	-	X	-	-	-	X	-	-	-
WYOMING	X	-	-	-	X	-	-	-	X	-	-	-
TOTAL STATES	9	25	3	14	28	11	8	6	23	14	9	8
% TOTAL U.S. 6 FOR CATEGORY	9.2	32.1	13.0	57.5	48.3	23.4	23.4	22.3	45.4	25.2	23.7	23.4

six States place "other limits" on SNF services. "Other limits" include limited to instate facility, prior authorization for specific services, and institutional service provided is subject to limitations specified for that service.

Intermediate care facility services for individuals age 65 and older in institutions for mental diseases mean ICF services that are provided to recipients who are determined to be in need of this service and are in institutions for mental diseases. Twenty-three States, do not provide ICF services for this age population. Fourteen States provide ICF services with no limitations, nine States require prior authorization and eight States have "other limits." "Other limits" include limited to instate facilities, facility must be located near to a community mental health center and be affiliated with its resources and prior authorization required for nonroutine therapy.

4.2.4 Services for Individuals Age 21 and Under

States may elect to provide two types of services for individuals age 21 and under: skilled nursing facility services and inpatient psychiatric services. "Skilled nursing facility services for individuals under age 21" (42 CFR 440.170(d)) are defined to be those services as specified in Section 4.1.5 that are provided to recipients under 21 years of age. Table 4.2.4 shows that SNF services for this population are not provided by six States. Twenty States provide SNF services to recipients under 21 years of age with no limits imposed and those States account for 18.9 percent of total Medicaid expenditures for all SNF services. Prior authorization is required by 19 States accounting for expenditures of 60.3 percent and "other limits" are imposed by 10 States accounting for expenditures of 63.6 percent of total Medicaid expenditures for all SNF services.

Inpatient psychiatric services for individuals under age 21 means services that are provided under the direction of a physician and are provided in an accredited facility or program (42 CFR 440.160). Federal regulations further specify certification of need, active treatment, and individual plans of care. Thirteen States do not provide inpatient psychiatric services to individuals under age 21 (Table 4.2.4). Twenty-nine States provide inpatient

Table 4.2.4

SUMMARY OF LIMITATIONS ON OPTIONAL SERVICES
SERVICES FOR INDIVIDUALS AGE 21 AND UNDER

STATE	SKILLED NURSING FACILITIES				INPATIENT PSYCHIATRIC			
	Not Provided	No Limits	Prior Authorization Required	Other Limits	Not Provided	No Limits	Prior Authorization Required	Other Limits
ALABAMA	-	-	X	-	-	-	X	X
ALASKA	-	-	X	-	-	X	-	-
ARKANSAS	-	-	X	-	-	X	-	-
CALIFORNIA	-	-	X	X	-	-	X	-
COLORADO	-	X	-	-	-	X	-	-
CONNECTICUT	-	X	-	-	-	X	-	-
DELAWARE	-	X	-	-	X	-	-	-
DIST COLUMBIA	-	X	-	-	-	X	-	-
FLORIDA	X	-	-	-	X	-	-	-
GEORGIA	-	-	X	-	X	-	-	-
HAWAII	-	-	X	-	X	-	-	-
IDAHO	-	X	-	-	X	-	-	-
ILLINOIS	-	X	-	-	-	X	-	-
INDIANA	-	-	-	X	-	-	-	X
IOWA	-	-	-	X	-	X	-	-
KANSAS	-	X	-	-	-	X	-	-
KENTUCKY	-	-	X	X	-	X	-	-
LOUISIANA	-	X	-	-	-	X	-	-
MAINE	-	X	-	-	-	X	-	-
MARYLAND	-	-	X	X	-	-	-	X
MASSACHUSETTS	-	-	X	-	-	-	-	X
MICHIGAN	-	-	X	X	-	-	-	X
MINNESOTA	-	X	-	-	-	X	-	-
MISSISSIPPI	-	-	X	-	X	-	-	-
MISSOURI	X	-	-	-	-	X	-	-
MONTANA	-	X	-	-	-	X	-	-
NEBRASKA	-	X	-	-	-	X	-	-
NEVADA	-	-	X	-	X	-	-	-
NEW HAMPSHIRE	-	-	X	-	X	-	-	-
NEW JERSEY	-	-	X	-	-	X	-	-
NEW MEXICO	-	X	-	-	X	-	-	-
NEW YORK	-	-	X	X	-	-	-	X
N CAROLINA	-	-	X	-	-	X	-	-
N DAKOTA	-	X	-	-	-	X	-	-
OHIO	-	X	-	-	-	X	-	-
OKLAHOMA	X	-	-	-	-	X	-	-
OREGON	-	X	-	-	-	X	-	-
PENNSYLVANIA	-	-	-	X	-	X	-	-
RHODE ISLAND	-	-	X	-	X	-	-	-
S CAROLINA	-	-	X	-	-	X	-	-
S DAKOTA	-	X	-	-	-	-	-	X
TENNESSEE	X	-	-	-	-	X	-	-
TEXAS	X	-	-	-	X	-	-	-
UTAH	-	X	-	-	-	X	-	-
VERMONT	-	-	-	X	-	X	-	-
VIRGINIA	-	X	-	-	X	-	-	-
WASHINGTON	X	-	-	-	-	X	-	-
W VIRGINIA	-	-	X	-	-	X	-	-
WISCONSIN	-	-	-	X	-	X	-	-
WYOMING	-	X	-	-	X	-	-	-
TOTAL STATES	6	20	19	10	13	29	2	7
% TOTAL U S $ FOR CATEGORY	5.7	18.9	60.3	63.6	0.0	50.9	35.8	13.4

psychiatric services with no limitations. These 29 States account for 50.9 percent of total Medicaid expenditures for inpatient psychiatric facility services for individuals under 21. Two States require prior authorization and seven States have "other limits" on inpatient psychiatric services. "Other limits" include restricted to inpatient facilities, services provided only after recertification that available local community resources for ambulatory care do not meet individuals treatment needs, and occupational/ recreational therapy must be ordered in writing by a physician.

4.2.5 Prescribed Drugs

Prescribed drugs are simple or compound substances or mixture of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are prescribed by a physician or other licensed practitioner of the healing arts within the scope of their professional practice as defined and limited by Federal and State law (42 CFR 440.120). The drugs must be dispensed by licensed authorized practitioners on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records. (Drugs provided to institutionalized Medicaid recipients are not included in the following discussion because they are provided as part of the range of services provided by the particular type of institutions rather than as a separate service.)

Table 4.2.5 displays limitations on prescribed drugs. Two States, Alaska and Wyoming, do not provide prescribed drugs as a separate service to Medicaid recipients while Indiana imposes no limitations on this service. States place limits on prescription quantities in three different ways: number of prescriptions that can be filled in a certain time period, number of prescriptions that can be refilled in a certain time period, and quantity of each prescription. Twelve States place limits on the number or cost of prescriptions that can be filled in a certain time period and expend 22.3 percent of the total Medicaid expenditures for drugs. The range was from three to six prescriptions that can be filled per month. Nine States limit the number of refills per prescription allowable in a certain time period. The majority of States with this limitation allow five refills every six months.

Table 4.2.5

SUMMARY OF LIMITATIONS ON OPTIONAL SERVICES
PRESCRIBED DRUGS

STATE	Not Provided	Limits On The Number/Cost Of Precriptions That Can Be Filled In A Certain Time Period	Limits On The Number Of Refills In A Certain Time Period	Limits On Quantity Of Any Single Prescription (Days)	Few or No Over the Counter Drugs Covered	Restrictive Formulary Status	Prior Authorization Required on Certain Drugs	Other Limits
ALABAMA	-	-	-	-	-	X	X	-
ALASKA	X	-	-	-	-	-	-	-
ARKANSAS	-	X	-	-	-	-	-	X
CALIFORNIA	-	-	-	X	X	X	X	-
COLORADO	-	-	-	-	X	X	X	-
CONNECTICUT	-	-	-	-	-	-	-	X
DELAWARE	-	-	-	-	X	-	-	X
DIST COLUMBIA	-	-	-	-	X	X	X	-
FLORIDA	-	X	-	-	-	-	-	X
GEORGIA	-	X	-	X	-	X	X	-
HAWAII	-	-	-	-	-	X	X	-
IDAHO	-	X	-	-	X	-	-	X
ILLINOIS	-	-	-	-	-	X	-	-
INDIANA	-	-	-	-	-	-	-	-
IOWA	-	-	-	-	X	-	X	X
KANSAS	-	-	-	X	-	-	X	X
KENTUCKY	-	-	-	-	-	-	-	X
LOUISIANA	-	-	-	-	-	-	-	X
MAINE	-	-	-	X	X	-	-	-
MARYLAND	-	-	X	X	X	-	X	X
MASSACHUSETTS	-	-	-	-	-	-	-	X
MICHIGAN	-	-	-	-	-	X	-	X
MINNESOTA	-	X	X	X	X	-	-	X
MISSISSIPPI	-	X	X	-	-	X	-	-
MISSOURI	-	X	-	-	X	X	X	-
MONTANA	-	-	-	-	X	-	-	-
NEBRASKA	-	-	-	-	X	-	X	X
NEVADA	-	X	-	-	X	-	-	-
NEW HAMPSHIRE	-	-	-	-	-	-	-	X
NEW JERSEY	-	-	X	X	-	-	X	X
NEW MEXICO	-	-	-	-	X	-	X	X
NEW YORK	-	-	-	-	-	X	-	-
N CAROLINA	-	-	-	-	X	-	-	-
N DAKOTA	-	-	-	-	-	-	-	X
OHIO	-	-	-	X	-	-	X	-
OKLAHOMA	-	X	X	X	X	-	-	-
OREGON	-	-	-	-	-	X	-	-
PENNSYLVANIA	-	-	-	X	-	X	X	-
RHODE ISLAND	-	-	-	-	-	X	X	-
S CAROLINA	-	X	X	X	X	X	X	X
S DAKOTA	-	-	-	-	X	-	-	-
TENNESSEE	-	X	X	-	X	X	-	-
TEXAS	-	X	X	X	-	X	-	-
UTAH	-	-	-	-	X	X	X	X
VERMONT	-	-	-	-	X	X	X	-
VIRGINIA	-	-	-	-	X	-	-	X
WASHINGTON	-	-	-	-	-	X	X	-
W VIRGINIA	-	-	X	X	X	-	X	-
WISCONSIN	-	-	-	-	X	X	X	-
WYOMING	X	-	-	-	-	-	-	-
TOTAL STATES	2	12	9	13	24	21	22	21
% TOTAL U S $ FOR CATEGORY	0.0	22.3	18.5	43.6	36.0	62.1	47.1	30.8

States further limit prescribed drugs by restricting the quantity of medication for a single prescription. Thirteen States impose this limitation and they account for 43.6 percent of total Medicaid expenditures for drugs. Generally this limit is stated in number of days or months supply and ranges from a 30-day supply to a 6-month supply. Twenty-four States choose to cover few or no over-the-counter drugs. Twenty-one States have restrictive formulary status; twenty-two States require prior authorization on certain drugs and 21 States place "other limits." Some of the "other limits" imposed on prescribed drug services were that brand name drug services must be documented as medically necessary, refills must be filled by same pharmacy as original prescription and flu and pneumococcal vaccines are covered only for persons age 65 and over.

4.2.6 Clinic, Emergency Hospital, and Transportation Services

Clinic services are preventive, diagnostic, therapeutic, rehabilitative or palliative items or services provided to an outpatient, by or under the direction of a physician or dentist, by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients (42 CFR 440.90). As presented in Table 4.2.6, three States (Alabama, Rhode Island, and Texas) do not provide clinic services. Ten States, expending 31.9 percent of the total Medicaid dollars for all services, provide clinic services with no limits. Eleven States, accounting for 17.0 percent of the total Medicaid dollars for all services, require prior authorization for clinic services and 36 States have "other limits." These "other limits" include limitations on Community Mental Health Center visits and limits on specific services and by specific practitioners. The 36 States account for 60.8 percent of the total Medicaid expenditures for all services.

Emergency hospital services is an optional service provided in forty-two States. Emergency hospital services means services that are necessary to prevent death or serious impairment of the health of a recipient and because of the threat to the life or health necessitates the use of the most accessible hospital available that is equipped to furnish the services (42 CFR 440.170(e)). The services will be provided at such a hospital even if it does not meet the conditions for participation under Medicare or the definition of inpatient or outpatient hospital services. Twenty-two States provide

Table 4.2.6

SUMMARY OF LIMITATIONS ON OPTIONAL SERVICES
CLINIC, EMERGENCY HOSPITAL AND TRANSPORTATION SERVICES

STATE	CLINIC				EMERGENCY HOSPITAL				TRANSPORTATION			
	Not Provided	No Limits	Prior Authorization Required	Other Limits	Not Provided	No Limits	Prior Authorization Required	Other Limits	Not Provided	No Limits	Prior Authorization Required	Other Limits
ALABAMA	X	-	-	-	-	-	X	X	-	-	-	X
ALASKA	-	X	-	-	-	X	-	-	-	-	X	X
ARKANSAS	-	-	-	X	-	-	-	X	-	-	X	-
CALIFORNIA	-	-	-	X	-	-	-	X	-	-	X	-
COLORADO	-	-	-	X	-	X	-	-	-	-	X	X
CONNECTICUT	-	-	-	X	X	-	-	-	-	X	-	-
DELAWARE	-	X	-	-	-	X	-	-	-	-	-	X
DIST COLUMBIA	-	-	X	X	-	X	-	-	X	-	-	-
FLORIDA	-	-	-	X	-	-	-	X	-	-	X	X
GEORGIA	-	-	-	X	X	-	-	-	-	-	-	X
HAWAII	-	-	-	X	-	X	-	-	-	-	X	-
IDAHO	-	-	-	X	-	-	-	X	-	-	-	X
ILLINOIS	-	X	-	-	-	X	-	-	-	-	X	-
INDIANA	-	-	X	-	-	X	-	-	-	-	X	-
IOWA	-	-	-	X	-	-	-	X	-	-	-	X
KANSAS	-	-	-	X	-	X	-	-	-	-	X	X
KENTUCKY	-	-	-	X	-	-	-	X	-	-	X	X
LOUISIANA	-	-	X	X	-	-	X	X	-	-	X	X
MAINE	-	-	-	X	-	-	-	X	-	-	-	X
MARYLAND	-	-	-	X	-	X	-	-	-	-	X	X
MASSACHUSETTS	-	-	X	X	-	X	-	-	-	-	X	-
MICHIGAN	-	-	-	X	-	-	-	X	-	-	-	X
MINNESOTA	-	X	-	-	-	X	-	-	-	-	X	-
MISSISSIPPI	-	-	-	X	-	-	-	X	-	-	-	X
MISSOURI	-	-	X	X	X	-	-	-	-	-	-	X
MONTANA	-	-	-	X	-	X	-	-	-	-	X	X
NEBRASKA	-	-	X	X	-	X	-	-	-	X	-	-
NEVADA	-	-	-	X	-	X	-	-	-	-	X	-
NEW HAMPSHIRE	-	-	-	X	-	-	-	X	-	-	-	X
NEW JERSEY	-	-	X	X	-	X	-	-	-	-	X	-
NEW MEXICO	-	-	X	X	-	-	-	X	-	-	X	-
NEW YORK	-	X	-	-	-	X	-	-	-	-	X	-
N CAROLINA	-	-	-	X	X	-	-	-	-	-	-	X
N DAKOTA	-	X	-	-	-	X	-	-	-	X	-	-
OHIO	-	-	-	X	-	-	-	X	-	-	X	X
OKLAHOMA	-	-	-	X	X	-	-	-	-	-	-	X
OREGON	-	-	X	X	-	X	-	-	-	-	X	-
PENNSYLVANIA	-	-	-	X	-	-	X	X	-	-	X	X
RHODE ISLAND	X	-	-	-	X	-	-	-	-	-	X	X
S CAROLINA	-	-	-	X	-	-	-	X	-	-	X	X
S DAKOTA	-	X	-	-	-	X	-	-	-	-	-	X
TENNESSEE	-	X	-	-	-	-	-	X	-	-	-	X
TEXAS	X	-	-	-	-	-	-	X	-	-	-	X
UTAH	-	-	X	X	-	X	-	-	-	-	X	-
VERMONT	-	-	-	X	-	-	-	X	-	-	-	X
VIRGINIA	-	-	-	X	-	X	-	-	-	-	X	-
WASHINGTON	-	X	-	-	-	X	-	-	-	-	-	X
W VIRGINIA	-	X	-	-	-	-	-	X	-	-	X	-
WISCONSIN	-	-	X	X	X	-	-	-	-	-	X	X
WYOMING	-	-	-	X	X	-	-	-	-	-	-	X
TOTAL STATES	3	10	11	36	8	22	3	20	1	3	28	31
% TOTAL U.S. $ FOR CATEGORY	5.7	31.9	17.0	60.8	10.7	46.1	8.6	43.2	0.6	1.9	75.4	44.5

emergency hospital services with no limitations and expend 46.1 percent of the total Medicaid expenditures for all services. Three States require prior authorization and 20 States place "other limits" on services. Generally, these "other limits" are those limits that a State normally imposes on inpatient and outpatient hospital services.

Transportation services include expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a recipient (42 CFR 440.170(a)). Transportation is furnished only by a provider to whom a direct vendor payment can be made by the agency. If other arrangements are made to assure transportation, FFP is available as an administrative cost. Travel expenses include the cost of transportation, the cost of meals and lodging en route and while receiving medical care, and the cost of an attendant to accompany the recipient, his meals, lodging and transportation.

Transportation is provided by 49 States with only the District of Columbia not providing transportation services. Connecticut, Nebraska and North Dakota provide transportation services without limitations. The remaining 46 States provide transportation with limitations. Twenty-eight States require prior authorization for transportation services. Thirty-one States expend 44.5 percent of total Medicaid dollars for all services and place such "other" limits as medical necessity required for out of State travel, transportation to physician's office not provided, and limit on number of trips per year.

4.2.7 Personal Care Services, Private Duty Nursing, Christian Science Sanitoria, and Christian Science Nursing

Personal care services in a recipient's home means services prescribed by a physician in accordance with the recipient's plan of treatment and provided by an individual who is qualified to provide the services, supervised by a registered nurse, and not a member of the recipient's family (42 CFR 440.170(f)). It should be noted that States which are granted a waiver under Section 2176 for home and community based services (that an individual needs to avoid institutionalization) are given the latitude to define personal care services differently. As of April 1, 1983, 27 States had been approved for Section 2176 waivers.

As shown in Table 4.2.7, personal care services were not provided by 30 States which expend 52.5 percent of total Medicaid dollars for all services. Two States provide personal care services with no limitations. Nine States require prior authorization and account for 32.2 percent of the total expenditures for home health services. Fifteen States place "other limits" on personal care services which include such limitations as a cap per recipient on personal care service expenditures, a limitation to individuals certified as otherwise requiring an institutional level of care, and a limit on the number of hours of service per time period.

Private duty nursing services means nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or SNF (42 CFR 440.80). These services must be provided by a registered nurse or a licensed practical nurse under the direction of the recipient's physician. The services must be provided in the recipient's home, in a hospital, or in a SNF.

Private duty nursing services are not provided in 32 States and account for 53.5 percent of the total Medicaid expenditures for all services. Two States, Nebraska, and North Dakota, place no limits on private duty nursing. Prior authorization is required by 11 States accounting for 35.9 percent of total Medicaid expenditures for all services. "Other limits" are imposed by 10 States accounting for 37.0 percent of the total Medicaid expenditures for all services. "Other limits" include limits on services provided in specific settings; e.g., only inpatient hospitals, and services limited to a specified number of days.

Christian Science sanitoria services means services that are provided in Christian Science sanitoriums that are operated by, or listed and certified by, the First Church of Christ, Scientist, Boston, Massachusetts (42 CFR 440.170(c)). These services are not provided by 33 States which account for 49.8 percent of the total Medicaid expenditures for all services. Eight States (17.2 percent of all expenditures) place no limitations on Christian Science sanitoria services. One State requires prior authorization for this service and nine States place other limits on Christian Science sanitoria

Table 4.2.7

SUMMARY OF LIMITATIONS ON OPTIONAL SERVICES

STATE	PERSONAL CARE SERVICES				PRIVATE DUTY NURSING				CHRISTIAN SCIENCE SANITORIA				CHRISTIAN SCIENCE NURSING			
	Not Provided	No Limits	Prior Authorization Required	Other Limits	Not Provided	No Limits	Prior Authorization Required	Other Limits	Not Provided	No Limits	Prior Authorization Required	Other Limits	Not Provided	No Limits	Prior Authorization Required	Other Limits
ALABAMA	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
ALASKA	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
ARKANSAS	-	-	-	X	X	-	-	-	X	-	-	-	X	-	-	-
CALIFORNIA	X	-	-	-	X	-	-	-	-	-	X	X	X	-	-	-
COLORADO	-	-	X	-	X	-	-	-	X	-	-	-	X	-	-	-
CONNECTICUT	X	-	-	-	-	-	-	X	X	-	-	-	X	-	-	-
DELAWARE	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
DIST COLUMBIA	-	X	-	-	X	-	-	-	X	-	-	-	X	-	-	-
FLORIDA	X	-	-	-	X	-	-	-	-	X	-	-	X	-	-	-
GEORGIA	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
HAWAII	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
IDAHO	-	-	-	X	X	-	-	-	X	-	-	-	X	-	-	-
ILLINOIS	X	-	-	-	-	-	X	-	-	X	-	-	X	-	-	-
INDIANA	X	-	-	-	-	-	-	X	-	X	-	-	-	X	-	-
IOWA	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
KANSAS	-	-	X	X	-	-	X	X	X	-	-	-	X	-	-	-
KENTUCKY	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
LOUISIANA	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
MAINE	X	-	-	-	X	-	-	-	-	X	-	-	-	X	-	-
MARYLAND	-	-	X	X	X	-	-	-	X	-	-	-	X	-	-	-
MASSACHUSETTS	-	-	-	X	-	-	X	X	-	X	-	-	-	X	-	-
MICHIGAN	-	X	-	-	X	-	-	-	-	-	-	X	X	-	-	-
MINNESOTA	-	-	-	X	-	-	-	X	-	X	-	-	X	-	-	-
MISSISSIPPI	X	-	-	-	X	-	-	-	-	-	-	X	X	-	-	-
MISSOURI	-	-	-	X	X	-	-	-	X	-	-	-	X	-	-	-
MONTANA	-	-	-	X	-	-	-	X	X	-	-	-	X	-	-	-
NEBRASKA	-	-	-	X	-	X	-	-	X	-	-	-	X	-	-	-
NEVADA	-	-	X	-	-	-	X	-	X	-	-	-	X	-	-	-
NEW HAMPSHIRE	-	-	-	X	-	-	X	X	-	X	-	-	-	X	-	-
NEW JERSEY	X	-	-	X	X	-	-	-	-	-	-	X	X	-	-	-
NEW MEXICO	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
NEW YORK	-	-	X	X	-	-	X	X	X	-	-	-	X	-	-	-
N CAROLINA	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
N DAKOTA	X	-	-	-	-	X	-	-	X	-	-	-	X	-	-	-
OHIO	X	-	-	-	-	-	-	X	-	-	-	X	X	-	-	-
OKLAHOMA	-	-	X	-	X	-	-	-	X	-	-	-	X	-	-	-
OREGON	-	-	X	-	-	-	X	-	-	-	-	X	X	-	-	-
PENNSYLVANIA	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
RHODE ISLAND	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
S CAROLINA	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
S DAKOTA	-	-	-	X	X	-	-	-	X	-	-	-	X	-	-	-
TENNESSEE	X	-	-	-	X	-	-	-	-	-	-	X	X	-	-	-
TEXAS	-	-	X	X	X	-	-	-	-	-	-	X	X	-	-	-
UTAH	X	-	-	-	-	-	X	-	X	-	-	-	X	-	-	-
VERMONT	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
VIRGINIA	X	-	-	-	X	-	-	-	-	X	-	-	X	-	-	-
WASHINGTON	X	-	-	-	-	-	X	X	X	-	-	-	X	-	-	-
W VIRGINIA	X	-	-	-	-	-	X	-	X	-	-	-	X	-	-	-
WISCONSIN	-	-	X	X	-	-	X	-	-	-	-	X	-	-	-	X
WYOMING	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
TOTAL STATES	30	2	9	15	32	2	11	10	33	8	1	9	45	4	0	1
% TOTAL U.S. FOR CATEGORY	52.5	4.9	32.2	42.6	53.5	0.7	35.9	37.0	49.8	17.2	11.9	33.0	90.6	6.6	0.0	2.8

services. Examples of "other limits" are limits on number of days, limits on type of facility (e.g., ICFs only), and limits on types of services provided (e.g., treatment with prayer or spiritual means alone not provided).

Christian Science nursing services mean services provided by nurses who are listed and certified by the First Church of Christ, Scientist, Boston, Massachusetts (42 CFR 440.170(b)). The services must be requested by the visiting nurse organization. These nursing services are not provided by 45 States accounting for 90.6 percent of total Medicaid expenditures for all services. Four States, Indiana, Maine, Massachusetts, and New Hampshire, provide Christian Science nursing services with no limits imposed. Wisconsin places the limitation that nursing services rendered in connection with treatment by prayer or spiritual means alone are not provided. California does not provide Christian Science nursing services but it does cover services provided by Christian Science Practitioners.

4.2.8 Optometrists, Eyeglasses, Dental Services, and Dentures

Optometrists are included in the 42 CFR 440.60 category of "medical or other remedial care provided by licensed practitioners." They are licensed practitioners and provide medical, remedial care, or services other than physicians' services, within the scope of practice as defined under the State law. Table 4.2.8 shows that optometrists' services are provided in all States except Tennessee. Seven States place no limitations on optometrists' services while 25 States, accounting for 43.1 percent of total Medicaid expenditures for "other practitioners' services," require prior authorization. Thirty-nine States that expend 86.4 percent of the total Medicaid dollars for "other practitioners' services" have other limits placed on optometrists' services. Examples of these "other limits" include specific services (e.g., orthoptics) not provided, services provided only following surgery, and number of eye examinations limited for a given time period.

Limitations on eyeglasses services are also found on Table 4.2.8. "Eyeglasses" according to 42 CFR 440.120(d) mean lenses, including frames, and other aids to vision prescribed by an optometrist or opthalmologist. Eyeglasses are not provided in the States of Delaware, Idaho, and Wyoming but Connecticut is the only State which provides eyeglasses without limitations.

Table 4.2.8

SUMMARY OF LIMITATIONS ON OPTIONAL SERVICES

STATE	OPTOMETRISTS' SERVICES				EYEGLASSES				DENTAL SERVICES				DENTURES			
	Not Provided	No Limits	Prior Authorization Required	Other Limits	Not Provided	No Limits	Prior Authorization Required	Other Limits	Not Provided	No Limits	Prior Authorization Required	Other Limits	Not Provided	No Limits	Prior Authorization Required	Other Limits
ALABAMA	-	-	X	X	-	-	X	X	X	-	-	-	X	-	-	-
ALASKA	-	X	-	-	-	-	X	X	-	-	-	X	X	-	-	-
ARKANSAS	-	-	X	-	-	-	X	-	-	-	X	X	-	-	X	X
CALIFORNIA	-	-	-	X	-	-	-	X	-	-	X	X	-	-	X	X
COLORADO	-	-	-	X	-	-	X	X	-	-	X	X	X	-	-	-
CONNECTICUT	-	X	-	-	-	X	-	-	-	-	-	X	-	-	-	X
DELAWARE	-	-	-	X	X	-	-	-	X	-	-	-	X	-	-	-
DIST COLUMBIA	-	-	X	X	-	-	-	X	-	-	X	X	-	-	-	X
FLORIDA	-	X	-	-	-	-	-	X	-	-	X	X	-	-	X	X
GEORGIA	-	-	X	X	-	-	X	X	-	-	-	X	-	-	X	X
HAWAII	-	-	-	X	-	-	X	-	-	-	X	X	-	-	X	X
IDAHO	-	-	-	X	X	-	-	-	X	-	-	-	X	-	-	-
ILLINOIS	-	-	-	X	-	-	X	-	-	-	X	X	-	-	X	X
INDIANA	-	-	X	-	-	-	X	X	-	-	X	-	-	-	X	-
IOWA	-	-	X	X	-	-	X	X	-	-	X	X	-	-	X	X
KANSAS	-	-	X	X	-	-	X	X	-	-	X	X	-	-	X	X
KENTUCKY	-	-	X	X	-	-	X	X	-	-	-	X	X	-	-	-
LOUISIANA	-	-	-	X	-	-	X	X	X	-	-	-	-	-	X	X
MAINE	-	-	-	X	-	-	-	X	-	-	X	X	-	-	-	X
MARYLAND	-	-	X	X	-	-	-	X	-	-	X	X	-	-	X	-
MASSACHUSETTS	-	-	-	X	-	-	-	X	-	-	X	X	-	-	X	X
MICHIGAN	-	-	X	X	-	-	X	X	-	-	-	X	-	-	X	X
MINNESOTA	-	-	X	X	-	-	X	X	-	-	X	X	-	-	X	X
MISSISSIPPI	-	-	-	X	-	-	-	X	-	-	-	X	X	-	-	-
MISSOURI	-	-	X	X	-	-	-	X	-	-	X	X	-	-	X	-
MONTANA	-	-	X	X	-	-	-	X	-	-	X	X	-	-	X	X
NEBRASKA	-	-	X	-	-	-	X	-	-	-	X	X	-	-	X	X
NEVADA	-	-	X	X	-	-	-	X	-	-	X	X	-	-	X	-
NEW HAMPSHIRE	-	-	-	X	-	-	-	X	-	-	-	X	X	-	-	-
NEW JERSEY	-	-	X	X	-	-	X	-	-	-	X	X	-	-	X	X
NEW MEXICO	-	X	-	-	-	-	X	X	-	-	X	X	-	-	X	X
NEW YORK	-	X	-	-	-	-	X	-	-	-	X	-	-	-	X	-
N CAROLINA	-	-	-	X	-	-	X	X	-	-	X	X	-	-	X	X
N DAKOTA	-	X	-	-	-	-	-	X	-	-	X	-	-	X	-	-
OHIO	-	-	X	X	-	-	X	X	-	-	X	X	-	-	X	-
OKLAHOMA	-	-	-	X	-	-	-	X	-	-	X	X	X	-	-	-
OREGON	-	-	X	X	-	-	X	-	-	-	X	X	-	-	X	-
PENNSYLVANIA	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-	X
RHODE ISLAND	-	-	X	X	-	-	X	X	-	-	X	X	-	-	X	-
S CAROLINA	-	-	X	X	-	-	-	X	-	-	-	X	-	-	-	X
S DAKOTA	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-	X
TENNESSEE	X	-	-	-	-	-	-	X	-	-	-	X	X	-	-	-
TEXAS	-	-	-	X	-	-	-	X	X	-	-	-	X	-	-	-
UTAH	-	-	X	X	-	-	X	X	-	-	X	X	-	-	X	X
VERMONT	-	-	X	X	-	-	X	X	-	-	-	X	-	-	-	X
VIRGINIA	-	-	X	X	-	-	X	X	-	-	X	X	X	-	-	-
WASHINGTON	-	-	-	X	-	-	-	X	-	-	-	X	-	-	X	-
W VIRGINIA	-	-	X	X	-	-	-	X	-	-	X	X	-	-	X	X
WISCONSIN	-	-	X	X	-	-	X	X	-	-	X	X	-	-	X	-
WYOMING	-	X	-	-	X	-	-	-	X	-	-	-	X	-	-	-
TOTAL STATES	1	7	25	39	3	1	26	39	6	0	31	41	13	1	29	26
% TOTAL U S FOR CATEGORY	0.3	11.3	43.1	86.4	0.5	1.2	59.5	68.0	3.9	0.0	76.1	85.0	13.2	0.2	77.2	52.0

Twenty-six States, accounting for 59.5 percent of the total Medicaid expenditures for all services, require prior authorization. Thirty-nine States accounting for 68.0 percent of the expenditures for all services, place "other limits" on eyeglasses. These "other limits" include the number of pairs of eyeglasses allowed per time period, restrictions on the quality/price of lenses and frames, and specific diopter criteria.

Dental services are an optional service displayed on Table 4.2.8. Dental services (42 CFR 440.100) mean diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist. The services include treatment of:

- The teeth and associated structure of the oral cavity; and
- Disease, injury, or impairment that may affect the oral or general health of the recipient.

A dentist is defined to be an individual licensed to practice dentistry or oral surgery.

Six States do not provide dental services. However, these six States account for 3.9 percent of the total Medicaid expenditures for dental services. This can be explained by the fact that EPSDT recipients in all States are provided dental services as a result of conditions noted during screenings. The remaining 44 States place limits on dental services; 31 States, accounting for 76.1 percent of the Medicaid expenditures for dental services, require prior authorization and 41 place other limits on dental services. These 41 States expend 85.0 percent of the total Medicaid dollars for dental services. Examples of "other limits" include limited emergency treatment, specific procedures not covered, and limits on number of exams, procedures, etc., within a specific time period.

Dentures are an optional service provided by some States. Dentures are defined to be artificial structures made by or under the direction of a dentist to replace a full or partial set of teeth (42 CFR 440.120). Dentures are not provided by 13 States and those 13 States account for 13.2 percent of the total Medicaid expenditures for all services. North Dakota, places no limits on denture services. Twenty-nine States require prior authorization on dentures and account for 77.2 percent of the total Medicaid expenditures on

all services. Other limits are placed by 26 States and include time restrictions on provision and replacement of dentures and specific types of dentures not covered.

4.2.9 Podiatrists' Services, Chiropractors' Services, Other Practitioners' Services, and Prosthetic Devices

Limitations on podiatrists' services are found on Table 4.2.9. Podiatrists' services are one of the services included under 42 CFR 440.60, "medical or other remedial care provided by licensed practitioners." These services include any medical or remedial care provided by a podiatrist licensed and within the scope of practice as defined under State law. Eleven States do not provide podiatrists' services and those 11 States account for 10.3 percent of the total Medicaid expenditures for "other practitioner services." Examples of "other practitioners" include chiropractors, professional nurses, podiatrists, psychologists, optometrists and Christian Science practitioners and naturopaths.

Four States, Montana, North Dakota, Texas, and West Virginia, offer podiatrists' services without limitations. Fifteen States, accounting for 49.2 percent of the total Medicaid expenditures for other practitioner services, require prior authorization for podiatrists' services. Thirty-two States (83.6 percent of expenditures) place "other limits" on podiatrists' services which range from limitations on type of treatment modality provided to limits on number of visits in a given time period.

Limitations on chiropractors' services are also found on Table 4.2.9 and are included in the 42 CFR 440.60 "medical or other remedial care provided by licensed practitioners." Chiropractors' services are defined to include only services that consist of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform. In addition to being licensed by the State, the chiropractor must also meet the standard issued by the Secretary of HHS. These standards include age, education, and licensure standards.

Chiropractors' services are not covered as an optional service in 24 States which account for 26.7 percent of the total expenditures for "other practitioner services." Three States, Connecticut, Nebraska and North Dakota,

Table 4.2.9

SUMMARY OF LIMITATIONS ON OPTIONAL SERVICES

STATE	PODIATRISTS' SERVICES				CHIROPRACTORS' SERVICES				OTHER PRACTITIONERS' SERVICES				PROSTHETIC DEVICES			
	Not Provided	No Limits	Prior Authorization Required	Other Limits	Not Provided	No Limits	Prior Authorization Required	Other Limits	Not Provided	No Limits	Prior Authorization Required	Other Limits	Not Provided	No Limits	Prior Authorization Required	Other Limits
ALABAMA	X	-	-	-	X	-	-	-	X	-	-	-	-	-	X	X
ALASKA	X	-	-	-	X	-	-	-	X	-	-	-	-	-	X	-
ARKANSAS	X	-	-	-	-	-	-	X	-	-	X	X	-	-	X	X
CALIFORNIA	-	-	X	X	-	-	-	X	-	-	-	X	-	-	X	X
COLORADO	-	-	-	X	X	-	-	-	X	-	-	-	-	-	-	X
CONNECTICUT	-	-	-	X	-	X	-	-	-	-	-	X	-	-	-	X
DELAWARE	-	-	-	X	X	-	-	-	-	-	-	X	-	-	-	X
DIST COLUMBIA	-	-	X	X	X	-	-	-	-	-	-	X	-	-	X	X
FLORIDA	X	-	-	-	X	-	-	-	-	-	-	X	-	-	-	X
GEORGIA	-	-	X	X	X	-	-	-	-	-	-	X	-	-	-	X
HAWAII	-	-	X	X	X	-	-	-	-	-	-	X	-	-	X	X
IDAHO	-	-	-	X	-	-	-	X	-	-	-	X	X	-	-	-
ILLINOIS	-	-	X	X	-	-	X	X	-	-	-	X	-	-	-	X
INDIANA	-	-	X	-	-	-	X	-	X	-	-	-	-	-	X	-
IOWA	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-	X
KANSAS	-	-	-	X	-	-	X	X	-	-	X	X	-	-	X	-
KENTUCKY	X	-	-	-	X	-	-	-	X	-	-	-	-	-	X	X
LOUISIANA	-	-	-	X	-	-	-	X	X	-	-	-	-	-	X	-
MAINE	-	-	-	X	-	-	-	X	-	-	-	X	-	X	-	-
MARYLAND	-	-	X	X	X	-	-	-	X	-	-	-	-	-	-	X
MASSACHUSETTS	-	-	-	X	X	-	-	-	-	-	-	X	-	-	-	X
MICHIGAN	-	-	-	X	-	-	-	X	-	-	-	X	-	-	X	X
MINNESOTA	-	-	-	X	-	-	-	X	-	-	-	X	-	-	X	X
MISSISSIPPI	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
MISSOURI	-	-	-	X	X	-	-	-	X	-	-	-	-	-	X	X
MONTANA	-	X	-	-	X	-	-	-	-	-	-	X	-	-	X	X
NEBRASKA	-	-	X	X	-	X	-	-	-	-	-	X	-	-	X	-
NEVADA	-	-	X	-	-	-	-	X	-	-	-	X	-	-	X	-
NEW HAMPSHIRE	-	-	-	X	-	-	-	X	-	-	-	X	-	-	X	-
NEW JERSEY	-	-	X	X	-	-	-	X	-	-	X	X	-	-	X	X
NEW MEXICO	-	-	X	X	X	-	-	-	-	-	X	X	-	-	X	-
NEW YORK	-	-	X	X	X	-	-	-	-	X	-	-	-	-	X	X
N CAROLINA	-	-	-	X	-	-	-	X	X	-	-	-	X	-	-	-
N DAKOTA	-	X	-	-	-	X	-	-	X	-	-	-	-	X	-	-
OHIO	-	-	-	X	-	-	-	X	-	-	X	X	-	-	X	-
OKLAHOMA	-	-	-	X	X	-	-	-	-	-	-	X	-	-	-	X
OREGON	-	-	X	X	-	-	-	X	-	-	-	X	-	-	X	-
PENNSYLVANIA	-	-	-	X	-	-	-	X	X	-	-	-	-	-	X	X
RHODE ISLAND	-	-	X	X	X	-	-	-	X	-	-	-	-	-	X	-
S CAROLINA	-	-	-	X	X	-	-	-	X	-	-	-	-	-	X	-
S DAKOTA	X	-	-	-	-	-	-	X	X	-	-	-	-	-	-	X
TENNESSEE	X	-	-	-	X	-	-	-	X	-	-	-	-	-	X	-
TEXAS	-	X	-	-	-	-	-	X	-	-	-	X	-	-	X	X
UTAH	-	-	X	-	X	-	-	-	-	-	X	X	-	-	X	X
VERMONT	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-	X
VIRGINIA	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
WASHINGTON	-	-	-	X	X	-	-	-	-	-	X	X	-	-	X	X
W VIRGINIA	-	X	-	-	-	-	-	X	-	-	X	X	-	-	X	-
WISCONSIN	X	-	-	-	-	-	X	X	-	-	X	X	-	-	X	-
WYOMING	X	-	-	-	X	-	-	-	X	-	-	-	-	-	-	X
TOTAL STATES	11	4	15	32	24	3	4	22	18	1	9	31	4	2	31	29
% TOTAL U S FOR CATEGORY	10.3	4.8	49.2	83.6	26.7	2.0	8.5	70.3	13.4	8.6	18.4	78.0	4.3	0.8	76.2	78.0

place no limitations on chiropractors' services. Prior authorization is required by four States and 22 States place other limits on chiropractors' services. The 22 States account for 70.3 percent of the total Medicaid expenditures for other practitioner services. The "other limits" include only emergency care provided and limits on number of visits per recipient per time period.

Limitations on other practitioners' services are found on Table 4.2.9. Optometrists', podiatrists', and chiropractors' services have been discussed above. Thus, the "other practitioners' services" displayed in this table include psychologists, professional nurses, Christian Science practitioners, and naturopaths, (42 CFR 440.60). These services are not provided in 18 States and the 18 States expend 13.4 percent of the total Medicaid expenditures for other practitioner services (including optometrists, podiatrists and chiropractors). One State, New York, offers other practitioner services with no limitations. Nine States require prior authorization and expend 18.4 percent of the total Medicaid expenditures for other practitioner services. Thirty-one States place other limits on other practitioners services. These 31 States account for 78.0 percent of the total Medicaid expenditures for other practitioner services. The "other limits" they place on these services include limits on number of visits to psychologists, certain types of therapy (sensitivity training) not covered, naturopathic services reviewed for appropriateness of billing, and audiologists services limited to the provision of hearing aids only.

Prosthetic devices are defined by 42 CFR 440.120(c) to mean replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of practice as defined by State law. The devices must:

- Artificially replace a missing portion of the body;
- Prevent or correct physical deformity or malfunction; or
- Support a weak or deformed portion of the body.

Four States, Idaho, Mississippi, North Carolina and Virginia, do not provide prosthetic devices. Those four States account for 4.3 percent of the total Medicaid expenditures for all services. The States of Maine and North Dakota

provide prosthetic devices without limitations. Thirty-one States, accounting for 76.2 percent of the total Medicaid expenditures for all services, require prior authorization and 29 States place other limits on prosthetic devices. The other limits placed by the 29 States (78.0 percent of expenditures) include certain devices provided only to recipients under age 21, restrictions on number of devices provided, repair of devices, and provided only on a physician's order.

4.2.10 Physical Therapy, Occupational Therapy, and Speech, Language and Hearing

Limitations on physical therapy services are displayed on Table 4.2.10. Physical therapy according to 42 CFR 440.110(a) means services prescribed by a physician and provided to a recipient by or under the direction of a qualified physical therapist. To be a qualified physical therapist an individual must be licensed by the State, where applicable, and be a graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent. Physical therapy includes any necessary supplies and equipment.

Physical therapy services are not provided by 14 States while Alaska, Connecticut and North Dakota provide physical therapy services without limitations. Sixteen States require prior authorization for physical therapy services and account for 57.5 percent of the total Medicaid expenditures for all services. Twenty-seven States place "other limits" on these services and account for 50.5 percent of the total Medicaid expenditures. "Other limits" include specific procedures not provided, limited to specific number of modalities per recipient per time period and limited to specified groups of recipients (e.g., homebound).

Occupational therapy is offered as an optional service to recipients in 27 States. Occupational therapy (42 CFR 440.110(b)) means services prescribed by a physician and provided to a recipient by or under the direction of a qualified occupational therapist. A qualified occupational therapist is an individual who is either registered by the American Occupational Therapy Association or who is a graduate of an approved occupational therapy program (by the Council on Medical Education of the American Medical Association) and

Table 4.2.10

SUMMARY OF LIMITATIONS ON OPTIONAL SERVICES
PHYSICAL THERAPY AND OTHER RELATED SERVICES

STATE	PHYSICAL THERAPY				OCCUPATIONAL THERAPY				SPEECH, HEARING, LANGUAGE			
	Not Provided	No Limits	Prior Authorization Required	Other Limits	Not Provided	No Limits	Prior Authorization Required	Other Limits	Not Provided	No Limits	Prior Authorization Required	Other Limits
ALABAMA	-	-	X	X	X	-	-	-	X	-	-	-
ALASKA	-	X	-	-	-	X	-	-	-	X	-	-
ARKANSAS	X	-	-	-	X	-	-	-	X	-	-	-
CALIFORNIA	-	-	X	-	-	-	X	X	-	-	X	X
COLORADO	-	-	-	X	-	-	-	X	-	-	X	-
CONNECTICUT	-	X	-	-	-	X	-	-	-	-	-	X
DELAWARE	X	-	-	-	X	-	-	-	X	-	-	-
DIST COLUMBIA	-	-	-	X	X	-	-	-	-	-	-	X
FLORIDA	X	-	-	-	X	-	-	-	-	-	-	X
GEORGIA	X	-	-	-	X	-	-	-	X	-	-	-
HAWAII	-	-	X	X	-	-	X	X	-	-	X	X
IDAHO	-	-	-	X	X	-	-	-	X	-	-	-
ILLINOIS	-	-	X	-	-	-	X	-	-	-	X	-
INDIANA	-	-	X	X	-	-	X	X	-	-	X	X
IOWA	-	-	-	X	-	-	-	X	-	-	-	X
KANSAS	-	-	-	X	-	-	-	X	-	-	X	X
KENTUCKY	-	-	-	X	-	-	-	X	-	-	X	X
LOUISIANA	X	-	-	-	X	-	-	-	X	-	-	-
MAINE	-	-	-	X	-	-	-	X	-	-	X	X
MARYLAND	-	-	X	X	X	-	-	-	-	-	X	X
MASSACHUSETTS	-	-	-	X	-	-	-	X	-	-	-	X
MICHIGAN	-	-	X	-	-	-	X	X	-	-	X	X
MINNESOTA	-	-	-	X	-	-	-	X	-	-	-	X
MISSISSIPPI	X	-	-	-	X	-	-	-	X	-	-	-
MISSOURI	-	-	-	X	-	-	-	X	-	-	-	X
MONTANA	-	-	-	X	-	-	-	X	-	-	-	X
NEBRASKA	-	-	-	X	X	-	-	-	-	-	-	X
NEVADA	-	-	X	X	-	-	X	X	-	-	X	X
NEW HAMPSHIRE	-	-	-	X	-	-	-	X	-	-	-	X
NEW JERSEY	-	-	X	X	-	-	X	X	-	-	X	X
NEW MEXICO	-	-	X	X	-	-	X	X	-	-	X	X
NEW YORK	-	-	X	X	-	-	X	X	-	-	X	X
N CAROLINA	X	-	-	-	X	-	-	-	X	-	-	-
N DAKOTA	-	X	-	-	-	X	-	-	-	X	-	-
OHIO	-	-	X	X	-	-	-	X	-	-	-	X
OKLAHOMA	X	-	-	-	X	-	-	-	X	-	-	-
OREGON	-	-	X	-	-	-	X	-	-	-	X	X
PENNSYLVANIA	X	-	-	-	X	-	-	-	X	-	-	-
RHODE ISLAND	X	-	-	-	X	-	-	-	X	-	-	-
S CAROLINA	X	-	-	-	X	-	-	-	X	-	-	-
S DAKOTA	-	-	-	X	X	-	-	-	X	-	-	-
TENNESSEE	X	-	-	-	X	-	-	-	X	-	-	-
TEXAS	X	-	-	-	X	-	-	-	X	-	-	-
UTAH	-	-	X	X	X	-	-	-	-	-	X	X
VERMONT	X	-	-	-	X	-	-	-	X	-	-	-
VIRGINIA	-	-	-	X	-	-	-	X	-	-	-	X
WASHINGTON	-	-	-	X	-	-	X	X	-	-	X	X
W VIRGINIA	-	-	X	-	X	-	-	-	-	-	X	-
WISCONSIN	-	-	X	-	-	-	X	-	-	-	X	-
WYOMING	-	-	-	X	X	-	-	-	X	-	-	-
TOTAL STATES	14	3	16	27	23	3	12	21	17	2	19	27
% TOTAL U.S. $ FOR CATEGORY	25.4	1.6	57.5	50.5	28.2	1.6	51.6	62.3	25.2	0.4	57.0	67.9

engaged in the supplemental clinical experience required by the American Occupational Therapy Association. Occupational therapy services include any necessary supplies and equipment.

Twenty-three States accounting for 28.2 percent of the total Medicaid expenditures for all services do not provide occupational therapy services. Alaska, Connecticut and North Dakota provide these services without limitations. Twelve States that expend 51.6 percent of the total Medicaid dollars for all services require prior authorization for occupational services. Twenty-one States (62.3 percent of total expenditures) place "other limits" on occupational therapy services. Examples of other limits include limits on number of visits per recipient per time period, services limited to specific programs (e.g., rehabilitative, recuperative), and services of privately practicing therapists not covered.

Services for individuals with speech, hearing and language disorders are provided as an optional service in 33 States. These services are diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist for which a patient is referred by a physician (42 CFR 440.110(c)). It includes any necessary supplies and equipment. A speech pathologist or audiologist is an individual who has a certificate of clinical competence from the American Speech and Hearing Association, has completed the equivalent educational requirements and work experience necessary for the certificate, or has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

Speech, hearing and language services are not provided in 17 States while Alaska and North Dakota are the only States which provide speech, hearing and language services without limitations. Nineteen States, accounting for 57.0 percent of the total Medicaid expenditures for all services, require prior authorization and 27 States place other limits on speech, hearing and language services. These 27 States (67.9 percent of total expenditures) place limits that range from certificates of need to services of privately practicing therapists not covered to limits per recipient per time period by facility type (e.g., home health agency, visiting nursing association).

4.2.11 Diagnostic Services, Screening Services, Preventive Services, and Rehabilitative Services

Diagnostic services (42 CFR 440.130(a)) include medical procedures or supplies recommended by a physician, or other licensed practitioner of the healing arts, within the scope of his practice under State law. The services must enable the practitioner to identify the existence, nature or extent of illness, injury, or other health deviation in a recipient.

Table 4.2.11 displays limitations on diagnostic services and shows that 32 States do not provide this service. Ten States (38.6 percent of expenditures) provide diagnostic services with no limitations. The District of Columbia and Washington require prior authorization for diagnostic services and six States place "other limits" on these services. Types of "other limits" include restrictions on the number of Pap smears in Michigan and in Delaware services are limited to rental of apnea monitors for infants with diagnosed near-miss sudden infant death syndrome.

Screening services (42 CFR 440.130(b)) mean the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases. Screening services are not provided in 35 States. Eight States (expending 32.2 percent of total Medicaid dollars for all services) place no limits on screening services. Seven States place "other limits" on these services which range from limiting services to recipients under age 21 while other States limit the frequency of particular tests. These States account for 17.6 percent of total Medicaid expenditures.

Limits on preventive services are displayed on Table 4.2.11 with only nine States providing preventive services without limitations. Preventive services (42 CFR 440.130(c)) are those that prevent disease, disability, and other health conditions or their progression; services that prolong life; and services that promote physical and mental health and efficiency. Preventive services must be provided by a physician or other licensed practitioner of the healing arts within the scope of practice under State law.

Table 4.2.11

SUMMARY OF LIMITATIONS ON OPTIONAL SERVICES
OTHER DIAGNOSTIC, SCREENING, PREVENTIVE SERVICES

STATE	DIAGNOSTIC SERVICES				SCREENING SERVICES				PREVENTIVE SERVICES				REHABILITATIVE SERVICES			
	Not Provided	No Limits	Prior Authorization Required	Other Limits	Not Provided	No Limits	Prior Authorization Required	Other Limits	Not Provided	No Limits	Prior Authorization Required	Other Limits	Not Provided	No Limits	Prior Authorization Required	Other Limits
ALABAMA	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
ALASKA	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
ARKANSAS	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
CALIFORNIA	-	-	-	X	-	-	-	X	-	-	-	X	-	-	X	X
COLORADO	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
CONNECTICUT	-	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-
DELAWARE	-	-	-	X	X	-	-	-	X	-	-	-	X	-	-	-
DIST COLUMBIA	-	-	X	-	-	-	-	X	-	-	X	-	-	-	X	-
FLORIDA	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
GEORGIA	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
HAWAII	-	-	X	-	-	X	-	-	-	X	-	-	-	X	-	-
IDAHO	X	-	-	-	X	-	-	-	X	-	-	-	-	-	-	X
ILLINOIS	-	X	-	-	X	-	-	-	-	-	-	X	-	-	X	-
INDIANA	-	X	-	-	-	-	-	X	-	X	-	-	-	-	X	-
IOWA	X	-	-	-	X	-	-	-	X	-	-	-	-	X	-	-
KANSAS	X	-	-	-	X	-	-	-	X	-	-	-	-	-	-	X
KENTUCKY	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
LOUISIANA	X	-	-	-	X	-	-	-	X	-	-	-	-	-	X	-
MAINE	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
MARYLAND	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
MASSACHUSETTS	-	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-
MICHIGAN	-	-	-	X	X	-	-	-	X	-	-	-	X	-	-	-
MINNESOTA	-	X	-	-	-	X	-	-	-	X	-	-	-	-	X	-
MISSISSIPPI	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
MISSOURI	X	-	-	-	X	-	-	-	-	-	-	X	-	-	-	X
MONTANA	-	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-
NEBRASKA	X	-	-	-	X	-	-	-	X	-	-	-	-	-	-	X
NEVADA	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
NEW HAMPSHIRE	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-	X
NEW JERSEY	-	X	-	-	-	X	-	-	-	X	-	-	-	-	X	X
NEW MEXICO	X	-	-	-	X	-	-	-	X	-	-	-	-	-	X	-
NEW YORK	-	X	-	-	-	X	-	-	-	X	-	-	-	-	X	X
N CAROLINA	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-	X
N DAKOTA	-	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-
OHIO	X	-	-	-	X	-	-	-	X	-	-	-	-	-	-	X
OKLAHOMA	X	-	-	-	X	-	-	-	X	-	-	-	-	-	-	X
OREGON	-	X	-	-	-	-	-	X	-	-	-	X	-	-	X	-
PENNSYLVANIA	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
RHODE ISLAND	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
S CAROLINA	X	-	-	-	-	-	-	X	X	-	-	-	X	-	-	-
S DAKOTA	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
TENNESSEE	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
TEXAS	X	-	-	-	X	-	-	-	X	-	-	-	-	-	-	X
UTAH	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
VERMONT	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
VIRGINIA	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
WASHINGTON	-	-	-	X	X	-	-	-	-	-	X	-	-	-	X	X
W VIRGINIA	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
WISCONSIN	X	-	-	-	X	-	-	-	X	-	-	-	X	-	-	-
WYOMING	X	-	-	-	X	-	-	-	X	-	-	-	-	-	-	X
TOTAL STATES	32	10	2	6	35	8	0	7	33	9	2	6	23	6	11	14
% TOTAL U S * FOR CATEGORY	40.6	38.6	1.0	19.7	50.1	32.2	0.0	17.6	43.8	33.9	2.0	20.2	29.9	7.2	49.0	50.6

Thirty-three States do not provide preventive services and those 33 States account for 43.8 percent of the total Medicaid expenditures for all services. The District of Columbia and Washington require prior authorization and six States place "other limits" on preventive services. The States placing "other limits" on preventive services accounted for 20.2 percent of the total Medicaid expenditures for all services. Examples of other limits include services limited to specific immunizations that are not available without cost through a local Health Department, services limited to those provided by a Mental Health Center, and services subject to limitations of each service category under which they fall.

Rehabilitative services (42 CFR 440.130(d)) are medical or remedial services for reduction of physical or mental disability and restoration of a recipient to his best possible functional level. The services must be recommended by a physician or other licensed practitioner of the healing arts within the scope of his practice under State law. Six States (CT, HI, IA, MA, MT, and ND) place no limits on the provision of these services. Twenty-three States, accounting for 29.9 percent of the total Medicaid expenditures for all services, do not provide rehabilitative services. Eleven States (49.0 percent of expenditures) require prior authorization before provision of the services and 14 States (50.6 percent of expenditures) place other limits on rehabilitative services. Other limits include services limited to specific number per recipient per time period, services subject to limitation of each service category under which they fall, and services limited to provision of blood for specific conditions.

4.3 MEDICALLY NEEDY COVERAGE AND LIMITATIONS

A State plan must specify that, as a mimimum, categorically needy recipients are provided the mandatory services. Additionally, if a State plan includes the medically needy, it must provide, as a minimum, the following services (42 CFR 440.220):

- Prenatal care and delivery services for pregnant women;
- Ambulatory services to individuals under age 18 and individuals entitled to institutional services;

- Home health services to individuals entitled to SNF services; and
- If the State plan includes services either in institutions for mental diseases or in ICF-MRs, it must offer either of the following to each of the medically needy groups:
  - The services contained in 42 CFR sections 440.10 through 440.50 and 440.165 (to the extent nurse-midwives are authorized to practice under State law or regulations); or
  - The services contained in any seven of the sections in 42 CFR 440.10 through 42 CFR 440.165.

The State can, in addition, provide any other services to the medically needy without being bound by requirements pertaining to a minimum number of services or a mix of institutional and non-institutional services. Furthermore, a State may offer one set of services for a certain medically needy group without being required to offer them to all the medically needy groups.

4.3.1 Summary of Limitations

Table 4.3.1 displays a summary of the limitations on medically needy services beyond those for the categorically needy. Thirty States have medically needy programs and 22 of the 30 have the same coverage for mandatory services for all medically needy groups as for the categorically needy. These 22 States account for 59.5% of total Medicaid expenditures expended by the States with Medically Needy programs. Nineteen of 22 States have the same coverage for optional services for all medically needy groups as for the categorically needy. Thus, in 19 of the 30 States with medically needy programs, the services are the same for all recipients.

4.3.2 Mandatory and Optional Service Restrictions for Medically Needy

Table 4.3.2 displays, for both mandatory and optional services, those States in which service coverage is more restrictive for all medically needy groups than the coverage for catgorically needy groups. ("NP" denotes that a service is not provided to the Medically Needy whereas, if a service is not provided to both the categorically needy and the medicly needy, it is denoted by an "S".) Eight States (AR, LA, OK, PA, RI, TN, WA, WI) have more restrictive limitations on the medically needy for at least one mandatory service. Outpatient hospital services are more restrictive in Rhode Island and Wisconsin; SNF services are more restrictive in Rhode Island and are not

Table 4.3.1

MEDICALLY NEEDY
SUMMARY OF LIMITATIONS ON SERVICES BEYOND THOSE FOR CATEGORICALLY NEEDY

STATE	MEDICALLY NEEDY PROGRAM	COVERAGE SAME AS CATEGORICALLY NEEDY FOR ALL MANDATORY SERVICES	COVERAGE SAME AS CATEGORICALLY NEEDY FOR ALL OPTIONAL SERVICES
ALABAMA	-	-	-
ALASKA	-	-	-
ARKANSAS	X	-	-
CALIFORNIA	X	S	S
COLORADO	-	-	-
CONNECTICUT	X	S	S
DELAWARE	-	-	-
DIST COLUMBIA	X	S	S
FLORIDA	-	-	-
GEORGIA	-	-	-
HAWAII	X	S	S
IDAHO	-	-	-
ILLINOIS	X	S	S
INDIANA	-	-	-
IOWA	-	-	-
KANSAS	X	S	-
KENTUCKY	X	S	S
LOUISIANA	X	-	-
MAINE	X	S	-
MARYLAND	X	S	S
MASSACHUSETTS	X	S	S
MICHIGAN	X	S	S
MINNESOTA	X	S	S
MISSISSIPPI	-	-	-
MISSOURI	-	-	-
MONTANA	X	S	S
NEBRASKA	X	S	S
NEVADA	-	-	-
NEW HAMPSHIRE	X	S	-
NEW JERSEY	-	-	-
NEW MEXICO	-	-	-
NEW YORK	X	S	S
N CAROLINA	X	S	S
N DAKOTA	X	S	S
OHIO	-	-	-
OKLAHOMA	X	-	-
OREGON	-	-	-
PENNSYLVANIA	X	-	-
RHODE ISLAND	X	-	-
S CAROLINA	-	-	-
S DAKOTA	-	-	-
TENNESSEE	X	-	-
TEXAS	-	-	-
UTAH	X	S	S
VERMONT	X	S	S
VIRGINIA	X	S	S
WASHINGTON	X	-	-
W VIRGINIA	X	S	S
WISCONSIN	X	-	-
WYOMING	-	-	-
TOTAL STATES	30	22	19
% TOTAL MEDICALLY NEEDY $	100	59.5	57.8

KEY: S = Same as Limitations for Categorically Needy

Table 4.3.2
MEDICALLY NEEDY

1. SUMMARY OF LIMITATIONS ON MANDATORY SERVICES BEYOND THOSE FOR CATEGORICALLY NEEDY

COVERAGE MORE RESTRICTIVE THAN CATEGORICALLY NEEDY

STATE	Inpatient Hospital	Outpatient Hospital	Rural Health Clinic	Other Lab and X-ray	Skilled Nursing Facilities	EPSDT Services	Family Planning	Physicians Services	Home Health Services	Nurse Midwife
ARKANSAS	S	S	S	S	NP	S	S	S	S	S
LOUISIANA	S	S	S	S	NP	S	S	S	S	S
OKLAHOMA	S	S	S	S	S	S	S	R	NP	S
PENNSYLVANIA	S	S	S	S	S	S	S	S	R	NP
RHODE ISLAND	S	R	S	S	R	S	S	S	S	S
TENNESSEE	S	S	S	S	NP	S	S	R	S	S
WASHINGTON	S	S	S	S	S	NP	R	S	R	S
WISCONSIN	S	R	S	S	S	S	S	S	S	S

2. SUMMARY OF LIMITATIONS ON OPTIONAL SERVICES BEYOND THOSE FOR CATEGORICALLY NEEDY

COVERAGE MORE RESTRICTIVE THAN CATEGORICALLY NEEDY

STATE	ICF	ICF-MR	Inpatient TB Facilities	SNF TB Facilities	ICF TB Facilities	Inpatient Mental Facility Serv	SNF Mental Facility Serv	ICF Mental Facility Serv	SNF Services For Under 21	Inpatient Psych Fac
ARKANSAS	NP	NP	S	NP	NP	S	NP	NP	NP	S
KANSAS	S	S	S	S	S	S	S	S	S	S
LOUISIANA	NP	NP	NP	S	S	NP	NP	NP	NP	NP
MAINE	S	S	S	S	S	S	S	NP	S	S
NEW HAMPSHIRE	NP	NP	S	S	S	S	S	NP	S	S
OKLAHOMA	S	S	S	S	S	S	S	S	S	S
PENNSYLVANIA	S	S	S	S	S	S	S	S	S	S
RHODE ISLAND	NP	NP	S	S	S	S	S	S	R	S
TENNESSEE	NP	NP	NP	NP	NP	NP	NP	NP	S	S
WASHINGTON	S	S	S	S	S	S	S	S	S	S
WISCONSIN	S	S	S	S	S	S	S	S	S	R

3. COVERAGE MORE RESTRICTIVE THAN CATEGORICALLY NEEDY

STATE	Clinic	Emergency Services	Transport	Personal Care	Private Duty Nurse	Christ Science Sanitoria	Christ Science Nursing	Optometrist	Eye-Glasses	Dental Service	Dentures
ARKANSAS	S	S	S	NP	S	S	S	S	S	S	S
KANSAS	S	S	S	S	S	S	S	S	S	S	S
LOUISIANA	S	S	S	S	S	S	S	S	S	S	S
MAINE	S	NP	S	S	S	S	S	S	S	S	S
NEW HAMPSHIRE	S	S	S	S	S	S	S	S	S	S	S
OKLAHOMA	S	S	R	S	S	S	S	S	S	R	S
PENNSYLVANIA	S	S	S	S	S	S	S	S	S	R	R
RHODE ISLAND	S	S	R	S	S	S	S	R	S	S	S
TENNESSEE	S	S	S	S	S	S	S	S	S	S	S
WASHINGTON	S	S	S	S	S	S	S	S	R	S	S
WISCONSIN	S	S	S	S	NP	S	S	NP	S	NP	S

4. COVERAGE MORE RESTRICTIVE THAN CATEGORICALLY NEEDY

STATE	Podiatrist	Chiropractor	Other Practitioners	Prosthetic Devices	Drugs	Physical Therapy	Occup Therapy	Speech, Hear & Language	Diagnostic Services	Screen Serv	Prevent Serv	Rehab Serv
ARKANSAS	S	S	S	S	S	S	S	S	S	S	S	S
KANSAS	S	S	S	S	S	S	S	S	S	S	S	NP
LOUISIANA	S	S	S	S	S	S	S	S	S	S	S	S
MAINE	S	S	NP	S	S	S	S	S	S	S	S	S
NEW HAMPSHIRE	S	S	S	S	S	S	S	S	S	S	S	S
OKLAHOMA	S	S	S	S	R	S	S	S	S	S	S	R
PENNSYLVANIA	S	S	S	R	NP	S	S	S	S	S	S	S
RHODE ISLAND	NP	S	S	R	S	S	S	S	S	S	S	S
TENNESSEE	S	S	S	S	S	S	S	S	S	S	S	S
WASHINGTON	S	S	S	R	S	R	S	NP	NP	S	S	R
WISCONSIN	S	NP	S	S	R	S	S	S	S	S	S	S

KEY: NP=Not Provided S=Same as Limitations for Categorically Needy R=More Restrictive Limitations than those for Categorically Needy

provided in Arkansas, Louisiana and Tennessee; EPSDT services are not provided in Washington; family planning services are more restrictive in Washington; physician services are more restrictive in Oklahoma and Tennessee; home health services are more restrictive in Pennsylvania and Washington and are not provided in Oklahoma; and nurse midwife services are not provided in Pennsylvania.

Table 4.3.2 also displays the status of limitations on optional services for all medically needy groups as compared to the same services provided to the categorically needy. Kansas has more restrictive limitations on one optional service and ten States have more restrictive limitations on three to eight optional services.

In most States, coverage of the medically needy as of March 1983 is the same as that in effect in March 1982. Only one State, Illinois, indicated restrictions on different groups of medically needy. This year it specified that unpregnant individuals in AFDC-Medical Assistance who are 18 or older are not covered. Other States changed the limitations on services. Louisiana no longer provides mandatory skilled nursing facility services to medically needy and Kansas no longer provides rehabilitation services to them. Previously in Oklahoma, restrictions on physician services for the medically needy differed from those for the categorically needy but now the limitations are the same for both groups. Podiatrist's services for medically needy in Pennsylvania were previously limited to school children but this restriction no longer applies. Wisconsin had formerly indicated that inpatient psychiatric services for medically needy patients under age 21 were not provided but now these services will be provided as a result of an EPSDT referral.

4.4 COST SHARING

States are permitted to require certain recipients to share some of the costs of Medicaid by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, copayments, or similar cost sharing charges (42 CFR 447.50). For States that impose cost sharing payments, the regulations specify the standards and conditions under which States may impose

cost sharing, set forth minimum amounts and the methods for determining maximum amounts, and describe limitations on availability of FFP that relate to cost sharing requirements.

4.4.1 Deductible, Coinsurance, Copayment, or Similar Cost Sharing Charge

With the passage of the Social Security Amendments of 1972, States were empowered to impose "nominal" cost sharing requirements on optional Medicaid services for cash assistance recipients, and on any services for the medically needy. Section 131 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 introduced major changes to Medicaid cost sharing requirements. States may now impose a nominal deductible, coinsurance, copayment, or similar charge upon both categorically needy and medically needy for any service offered under the State Plan. Public Law 97-248, TEFRA, has been in effect since October 1982 and it prohibits imposition of cost sharing on the following:

- Services furnished to individuals under 18 years of age (or up to 21 at State option);
- Pregnancy related services (or, at State option, any service provided to pregnant women);
- Services provided to certain institutionalized individuals, who are required to spend all of their income for medical care except for a personal needs allowance;
- Emergency services;
- Family planning services and supplies; and
- Services furnished to categorically needy HMO enrollees (or, at State option, services provided to both categorically needy and medically needy HMO enrollees).

In addition, no more than one type of charge can be imposed on any service.

Table 4.4.1 compares for each State cost sharing policies in effect as of February 1982 and March 1983. This table presents a snapshot of copayment policies in effect at two points in time. Because these points in time also correspond to a pre-TEFRA period and a post-TEFRA period, the data may provide some insight into the impacts of TEFRA on State Medicaid cost sharing policies.

TABLE 4.4.1

COMPARISON OF CHARGES IMPOSED ON RECIPIENTS IN FEBRUARY 1982 AND MARCH 1983

FEBRUARY 1982					MARCH 1983			
STATE	SERVICE	ELIGIBILITY GROUPS	COPAY AMOUNT	APPLICABLE TO	SERVICE	ELIGIBILITY GROUPS	COPAY AMOUNT	APPLICABLE TO
Alabama	Drugs	All	$ .50		Drugs	All	Variable	Pregnant Women
Alaska	None				None			
Arkansas	Drugs	All	$1.00		None			
California	Drugs	All	$1.00		Drugs	All	$1.00	Age 12+ (waiver)
	Outpatient Hospital	All	$1.00		Outpatient Hospital	All	$1.00	
	--Emergency Room (Inappropriate Use)	All	$5.00		--Emergency Room (Inappropriate Use)	All	$5.00	
Colorado	None				None			
Connecticut	None				None			
Delaware	None				None			
District of Columbia	Drugs	All	$ .50		Drugs	All	$ .50	
	Eyeglasses	All	$2.00		Eyeglasses	All	$2.00	
Florida	Dentures	All	5%		Dentures	All	5% coinsurance	Age 21+; Pregnant
	Prosthetic Devices	All	5%		Prosthetic Devices	All	5% coinsurance	Women
	--Hearing Aids				--Hearing Aids			
Georgia	Drugs	All	Variable[1/]		None			
	Podiatrist	All	Variable[1/]					
	Prosthetic Devices	All	Variable[1/]					
	Other Practitioner --Psychologist	All	Variable[1/]					
	Transportation	All	Variable[1/]					
	Dental	All	Variable[1/]					
Hawaii	None				None			
Idaho	Drugs	All	$ .50		None			
Illinois	None				Inpatient	All	Variable[2/]	

TABLE 4.4.1 (CONTINUED)

COMPARISON OF CHARGES IMPOSED ON RECIPIENTS IN FEBRUARY 1982 AND MARCH 1983

FEBRUARY 1982					MARCH 1983			
STATE	SERVICE	ELIGIBILITY GROUPS	COPAY AMOUNT	APPLICABLE TO	SERVICE	ELIGIBILITY GROUPS	COPAY AMOUNT	APPLICABLE TO
Indiana	None				None			
Iowa	Dental	All	$3.00		Dental	All	$3.00	Age 21+
	Prosthetic Devices				Prosthetic Devices			
	--Hearing Aids	All	$3.00		--Hearing Aids	All	$3.00	
					--Orthopedic Shoes	All	$2.00	
					Drugs	All	$ .50	
	Optometrist	All	$2.00		Optometrist	All	$2.00	
	Podiatrist	All	$1.00		Podiatrist	All	$1.00	
	Chiropractor	All	$ .50		Chiropractor	All	$ .50	
	Other Practitioner	All	$2.00		Other Practitioner			
					--Psychologist	All	$2.00	
	Physical Therapy	All	$ .50		Medical Equipment & Supplies	All	$2.00	
	Medical Equipment & Supplies	All	$2.00		Eyeglasses			
	Transportation				--Optician Services	All	$2.00	
	--Ambulance	All	$2.00		Rehabilitation Agency	All	$2.00	
Kansas	Chiropractor	All	$ .50		Chiropractor	All	$ .50	
	Dental	All	$ .50		Dental	All	$ .50	
	Drugs	All	$ .50		Drugs	All	$ .50	
	Optometrist	All	$ .50		Optometrist	All	$ .50	
	Other Practitioner				Other Practitioner			
	--Psychologist	All	$ .50		--Psychologist	All	$ .50	
	Transportation				Transportation			
	--Nonemergency Ambulance	All	$ .50		--Nonemergency Ambulance	All	$ .50	
Kentucky	None				None			
Louisiana	None				None			
Maine	Drugs	All	$ .50		Drugs	All	$ .50	Age 21+; Pregnant Women
Maryland	Drugs	All	$ .50		None			

TABLE 4.4.1 (CONTINUED)

COMPARISON OF CHARGES IMPOSED ON RECIPIENTS IN FEBRUARY 1982 AND MARCH 1983

FEBRUARY 1982					MARCH 1983			
STATE	SERVICE	ELIGIBILITY GROUPS	COPAY AMOUNT	APPLICABLE TO	SERVICE	ELIGIBILITY GROUPS	COPAY AMOUNT	APPLICABLE TO
Massachusetts	None				None			
Michigan	Dental	All	$3,00		Dental	All	$3.00	Age 21+; Pregnant Women
	Optometrist	All	$2.00		Drugs	All	$ .50	
	Podiatrist	All	$2,00		Optometrist	All	$2.00	
	Chiropractor	All	$1.00		Podiatrist	All	$2.00	
	Prosthetic Devices --Hearing Aid	All	$3,00		Chiropractor	All	$1.00	
					Prosthetic Devices --Hearing Aid	All	$3.00	
Minnesota	None				None			
Mississippi	Dental	All	$2.00		None			
	Drugs	All	$ .50					
	Eyeglasses	All	$3.50					
	Transportation	All	$3,00					
Missouri	Speech, Hearing, Language --Audiology	All	Unknown		Speech, Hearing, Language --Audiology	All	Variable[3/]	Age 21+; Pregnant Women
	Dental	All	Unknown		Dental	All	5%	
	Dentures	All	Unknown		Dentures	All	Variable[3/]	
	Eyeglasses	All	Unknown		Optometrist	All	Variable[3/]	
	Optometrist	All	Unknown		Podiatrist	All	Variable[3/]	
	Podiatrist	All	Unknown		Inpatient	All	$10.00	
					Outpatient	All	$3.00	
					Drugs	All	Variable[3/]	
Montana	Drugs	All	$ .50		Drugs	All	$ .50	

TABLE 4.4.1 (CONTINUED)

COMPARISON OF CHARGES IMPOSED ON RECIPIENTS IN FEBRUARY 1982 AND MARCH 1983

FEBRUARY 1982					MARCH 1983			
STATE	SERVICE	ELIGIBILITY GROUPS	COPAY AMOUNT	APPLICABLE TO	SERVICE	ELIGIBILITY GROUPS	COPAY AMOUNT	APPLICABLE TO
Nebraska	None				None			
Nevada	Chiropractor	All	$1.00		Chiropractor	All	$1.00	Age 19+
	Clinic				Clinic			
	--Mental Health	All	$1.00		--Mental Health	All	$1.00	
	Dental	All	$2.00		Dental	All	$2.00	
	Dentures	All	$3.00		Dentures	All	$3.00	
	Drugs	All	$1.00		Drugs	All	$1.00	
	Eyeglasses	All	$3.00		Eyeglasses	All	$3.00	
	Inpatient Mental Disease Age 65+	All	50% 1st Day		Inpatient Mental Disease Age 65+	All	50% 1st Day	
	SNFs under 21	All	50% 1st Day		SNFs under 21	All	50% 1st Day	
	PT,OT, Speech/Hearing	All	$1.00		PT,OT, Speech/Hearing	All	$1.00	
	Podiatrist	All	$1.00		Podiatrist	All	$1.00	
	Prosthetic Devices	All	$3.00		Prosthetic Devices	All	$3.00	
	Transportation				Transportation			
	--Ambulance	All	$3.00		--Ambulance	All	$3.00	
	--Taxi	All	$1.00		--Taxi	All	$1.00	
	--Medivan	All	$2.00		--Medivan	All	$2.00	
	ICFs	All	50% 1st Day		ICFs	All	50% 1st Day	
	ICF-MR	All	50% 1st Day		ICF-MR	All	50% 1st Day	
New Hampshire	None				Drugs	All	$1.00	Age 18+
New Jersey	None				None			
New Mexico	Dental	All	$2.00		Dental	All	$2.00	Age 18+; Pregnant
	Drugs	All	$ .25		Drugs	All	$ .25	Women
New York	None				None			

TABLE 4.4.1 (CONTINUED)

COMPARISON OF CHARGES IMPOSED ON RECIPIENTS IN FEBRUARY 1982 AND MARCH 1983

FEBRUARY 1982					MARCH 1983			
STATE	SERVICE	ELIGIBILITY GROUPS	COPAY AMOUNT	APPLICABLE TO	SERVICE	ELIGIBILITY GROUPS	COPAY AMOUNT	APPLICABLE TO
North Carolina	Chiropractor	All	$ .50		Chiropractor	All	$ .50	Age 18+; Pregnant Women
	Clinic	All	$1.00		Clinic	All	$1.00	
	Dental	All	$2.00		Dental	All	$2.00	
	Drugs	All	$ .50		Drugs	All	$ .50	
	Eyeglasses	All	$2.00		Eyeglasses --Each pair & repair of $5+	All	$2.00	
	Inpatient--for 1st 30 Days; Maximum 50% of cost	MN	$2.00		Inpatient--for 1st 30 Days	MN	$2.00	
	Optometrist	MN	$1.00		Optometrist	MN	$1.00	
	Outpatient	MN	$1.00		Outpatient	MN	$1.00	
	Physician	MN	$1.00		Physician	MN	$1.00	
					Podiatrist	MN	$2.00	
					Rehabilitative --Nonhospital dialysis	MN	$2.00	
North Dakota	Eyeglasses --For 2nd or more pairs in a calendar year	All	$3.00		Eyeglasses --For 2nd or more pairs in a calendar year	All	$3.00	
Ohio	None				None			
Oklahoma	None				None			
Oregon	None				None			
Pennsylvania	None				None			
Rhode Island	None				None			
South Carolina	Dental--Per Procedure	All	$1.00		Dental--Per Procedure	All	$1.00	Age 21+; Pregnant Women
	Drugs	All	$ .50		Drugs	All	$ .50	
	Optometrist	All	$1.00		Optometrist	All	$1.00	
	Podiatrist	All	$1.00		Podiatrist	All	$1.00	

COMPARISON OF CHARGES IMPOSED ON RECIPIENTS IN FEBRUARY 1982 AND MARCH 1983

FEBRUARY 1982					MARCH 1983			
STATE	SERVICE	ELIGIBILITY GROUPS	COPAY AMOUNT	APPLICABLE TO	SERVICE	ELIGIBILITY GROUPS	COPAY AMOUNT	APPLICABLE TO
South Dakota	Drugs	All	$ .50		Drugs Inpatient--Per Stay Outpatient Physician--Per Service Dental--Per Service Dentures--Per Service	All All All All All All	$1.00 $25.00 5% $1.00 $1.00 $2.00	
Tennessee	None				None			
Texas	None				None			
Utah	None				None			
Vermont	Drugs	All	$1.00		Drugs	All	$1.00	
Virginia	Eyeglasses	All	$2.00		Optometrist --Eye exams Clinic Inpatient Outpatient --Nonemergency Physician	 All All MN MN MN	 $1.00 $1.00 $30.00 Deductible $2.00 $1.00	Age 21+; Pregnant Women
Washington	Outpatient --Emergency Room Inpatient --Each admission	 MN MN	 $2.00 $85.00		None			
West Virginia	Drugs	All	$ .50 on ≤$10.99 $1.00 on ≥$11.00		Drugs	All	$ .50 on ≤$11.00 on $1.00 on ≥$11.00	Age 18+

TABLE 4.4.1 (CONTINUED)

COMPARISON OF CHARGES IMPOSED ON RECIPIENTS IN FEBRUARY 1982 AND MARCH 1983

FEBRUARY 1982					MARCH 1983			
STATE	SERVICE	ELIGIBILITY GROUPS	COPAY AMOUNT	APPLICABLE TO	SERVICE	ELIGIBILITY GROUPS	COPAY AMOUNT	APPLICABLE TO
Wisconsin	None				Inpatient--Mental Disease	All*	$75.00/stay	Age 18+; Pregnant Women
					Outpatient	All*	Variable[4/]	
					Aide	All*	$1.00	
					Durable Medical Equipment	All	$1.00	
					Optometrist	All*	Variable[5/]	
					Chiropractor --per procedure	All*	$ .50	
					Dental	All*	Variable[6/]	
					Physical & Occupational Therapy --per 15 minutes	All	$ .50	
					Speech, Hearing, Language	All	Variable[7/]	
					Drugs	All	$ .50	
					Dentures--per service	All*	$3.00	
					Prosthetic Devices --Hearing Aids	All	Variable[5/]	
					Eyeglasses	All*	Variable[5/]	
					Transportation	All	Variable[8/]	
Wyoming	None				None			

1/ $.50 on $10.00 or less; $1.00 on $10.01 - $25.00; $2.00 on $25.01 - $50.00; $3.00 on $50.01+.

2/ $2.00 for per diem of $257 - 325; $3.00 for per diem over $325.

3/ $.50 on $10.00 or less; $1.00 on $11.00 - $25.00; $2.00 on $26.00 - $50.00; $3.00 on $51.00+.

4/ $.50 per hour for independent nursing services; $.50 per day for day treatment services.

5/ $.50 - $1.00 per procedure.

6/ $1.00 - $3.00.

7/ $.50 per 15 minutes for some services; $1.00 per procedure for others.

8/ $1.00 - 2.00.

*Service for which these charges are imposed are offered only to categorically needy recipients so these copayments do not apply to medically needy recipients.

In 1982 25 States (accounting for 46.8 percent of total Medicaid expenditures for FY 81) imposed some form of cost sharing but by 1983 only 22 States (accounting for 50.2 percent of total Medicaid expenditures, for FY 82) used cost sharing. Six States (Arkansas, Georgia, Idaho, Maryland, Mississippi, and Washington) had copayments in 1982 but dropped them in 1983 while three States (Illinois, New Hampshire, and Wisconsin) which did not use cost sharing measures in 1982 added them by 1983. Also by March 1983, North Carolina, South Dakota and Virginia increased the number of services on which copayments were required.

While emergency services are excluded from cost sharing, States may apply for waivers of nominal amounts for nonemergency services furnished in hospital emergency rooms, such a waiver allows States to impose a copayment amount up to twice the current maximum for such services. Approval of a waiver request by HCFA is based partly on the State's assurances that recipients will have accessibility to alternative sources of care. As indicated in Table 4.4, California has such a waiver.

Under the columns for eligibility groups, only North Carolina, Virginia and Wisconsin imposed different cost sharing on the categorically needy and the medically needy. Wisconsin had more charges on services for the categorically needy but this was due to the fact that these services were not offered to the medically needy. The term "all" in this column denotes either categorically needy and medically needy combined or categorically needy only because the State does not have a medically needy program.

The column "applicable to" in Table 4.4.1 indicates specific groups of people on whom charges are imposed. This column is blank for February 1982 since States did not specify such groups. For March 1983, when States indicated groups of people on whom charges were imposed, these groups are listed only once for that State but the information is relevant for each service. The term "pregnant women" in this column means that charges are imposed on services to pregnant women which are unrelated to pregnancy. While States may impose copayments on individuals age 18 or older, seven States indicated that charges apply to persons age 21 or older and one State applies cost sharing on persons age 19 or older. California has a section 1115(a) waiver which allows copayments to be charged on persons over age 12.

5. MEDICAID PROVIDER REIMBURSEMENT

This section presents an introduction to the principles of Medicaid provider reimbursement and current State reimbursement methods and rates for selected services.

5.1 MEDICAID PRINCIPLES OF REIMBURSEMENT

From the inception of Medicare and Medicaid in 1965, there were two fundamental axioms related to provider reimbursement. The first was that reimbursement be based upon reasonable cost or reasonable charges; basically the same philosophy used by private insurance carriers. This, it was reasoned, would ensure equity of reimbursement and adequate participation on the part of hospitals and physicians to ensure recipient access to quality mainstream medicine; i.e., traditional, private, fee-for-service care--just as that enjoyed by privately insured citizens. The second axiom was freedom of choice; meaning that Medicare and Medicaid recipients would be free to choose from among many providers of care on the basis of convenience and satisfaction. As detailed in Chapter 3, the 1972 Social Security Amendments liberalized eligibility for Medicaid to include SSI Income recipients (cash assistance to poor elderly, blind and disabled) and; at State option, certain optionally categorically needy groups and certain medically needy people who would otherwise qualify for the cash assistance programs if it were not for moderately excessive income or resources. These policy decisions set the stage for explosive growth in Medicaid expenditures throughout the remainder of the seventies. Up through FY 1981, Medicaid experienced double-digit annual growth rates, with hospitals and nursing homes representing three-quarters of total national expenditures.

Although Medicaid has been unquestionably successful in improving access by the poor to health services generally (Davis and Schoen, 1978) it has been much less successful in ensuring access to mainstream medical care.[1/] As gatekeepers to the rest of the health care system, private physicians did not respond to the program as its architects had assumed. Part of this has to do with the welfare stigma of Medicaid clientele and part to do with reimbursement rates for both Medicare and Medicaid falling behind those offered by private insurance carriers. Over 25 percent of the nation's private practice physicians refuse to treat Medicaid patients, and participation among key specialists such as OB-GYNs is even lower. [2/] In the nation's highly urbanized areas in which the majority of Medicaid recipients live, low office-based physician participation rates drive large numbers of Medicaid recipients to costly hospital-based settings for routine primary care; hence, higher costs per recipient.

Quite inadvertently, the architects of the Medicaid program designed built-in reimbursement incentives that would undermine its overall goal--access by the poor to quality mainstream medicine at reasonable costs. In the late seventies through 1980 States tried, with varying levels of success, to contain costs of the program through the use of more stringent eligibility requirements, imposition of service cutbacks and limitations, tighter administrative controls, and postponement of increases in physician reimbursement. Although numbers of recipients declined, the cost per recipient continued to rise sharply. It became obvious that something had to be done about Medicaid cost-based provider reimbursement incentives for hospitals and nursing homes which had no real incentive to contain rising costs. Since the unit of payment was per diem, there was even an incentive to maximize utilization so long as the Medicaid revenue played a useful role in the overall financial health of hospitals and nursing homes. Further, Medicaid eligibility rules lead physicians to institutionalize patients so they would be eligible for needed

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[1/] Davis and Schoen, Health and the War on Poverty, A Ten Year Appraisal; Brookings Institution, 1978.

[2/] Mitchell and Cromwell, "Large Medicaid Practices and Medicaid Mills," JAMA, November 1980.

services. The first significant legislative step to redress perverse provider incentives came in 1980 with the Omnibus Reconciliation Act of 1980 (PL 96-499). The Act replaced Section 249(a) of the 1972 Social Security Amendments requiring Medicare-based retrospective cost reimbursement principles for nursing homes. States were freed to reimburse nursing homes on the basis of "reasonable and adequate to the costs which must be incurred by efficiently and economically operated facilities." Many States moved swiftly to implement prospective reimbursement methodologies to curb inflation in nursing home costs.

The second significant step in reforming Medicaid provider reimbursement came with passage of the Omnibus Budget Reconciliation Act of 1981 (PL 97-35). Among other things, the Act, implemented by Federal regulations on September 30, 1981, granted significant new flexibility to the States in setting provider reimbursement policies for hospitals (Section 2173) and physicians (Section 2174) by relaxing the constraints which tied payments to Medicare retrospective cost-reimbursement principles. States quickly began to adopt alternate payment methods tailored to their own unique needs. The Act gave States waiver authority to restrict freedom of choice (Section 2175) and to eliminate the institutional bias towards institutional long-term care through home and community-based care (Section 2176). The Act also gave the States new flexibility to enter into prepaid service arrangements with non-federally qualified HMOs and to impose certain co-payments on service use by Medicaid recipients.

Although precise access and fiscal impacts of OBRA 81 are unknown at this time, policymakers at the Federal and State levels have been quick to recognize the fact that from FY 1981 to FY 1982, total Federal and State Medicaid expenditures grew by only 9.9 percent! This annual rate of growth was less than three-quarters of the annual rate of increases in expenditures for the past year and was the lowest since the inception of the program. Moreover, this reduction in the rate of increase in Medicaid expenditures took place during a period when rates of increase for Medicare was 11.7 percent and the

Medical component of the Consumer Price Index progressed at 11.6 percent. Total health care expenditures for all Americans in 1982 increased by 12.7 percent over the 1981 levels.[3/]

The third significant piece of legislation affecting Medicaid provider reimbursement policies is the Tax Equity and Fiscal Responsibility Act of 1982. TEFRA actually rescinded some of the flexibility given to the States through OBRA 81 by removing the authority given to the Secretary of DHHS to grant waivers for capitation and prepayment systems to other than federally qualified HMOs and restricted the imposition of nominal copayments by exempting from any copayment certain recipient types and services. The TEFRA contained two other important provisions related to Medicaid reimbursement. The first was a requirement that the Secretary of DHHS recommend a system of prospective reimbursement for the Medicare program which might apply to the Medicaid inpatient reimbursement setting. The second was an expansion of Section 223 limitations on hospital charges from routine hospital costs per day to the cost per case, including ancillary costs. Special adjustments are to be made for hospitals which have a disproportionate load of low income or Medicare patients, and for psychiatric hospitals. Non-SMSA hospitals with less than 50 beds will be excluded from the limitations.

The final legislative step thus far to reform Medicaid provider reimbursement is the Social Security Act Amendments of 1983. This Act mandates a three-year phase-in of a case rate prospective reimbursement system for Medicare that could also be adopted by State Medicaid Agencies. The Medicare Prospective Payment System (PPS) is based on a prospectively determined rate for each patient according to age, sex and diagnostically-related grouping (DRG). To date, several State Medicaid programs are studying adaptation of the new Medicare PPS concept to their own hospital reimbursement system.[4/]

[3/] Gibson, Waldo, and Levit, National Health Expenditures, 1982; Health Care Financing Review, Fall, 1983.

[4/] Clinkscale, Robert, "Impact of Medicare's Prospective Payment System (PPS) on State Medicaid Programs," Proceedings, First National DRG Conference, Atlantic City, N.J., 1983.

In summary, the above discussion represents a historical perspective or context in which to consider how States altered their Medicaid provider reimbursement policies between March 1982 and March 1983. The March 1982 Analysis of State Medicaid Program Characteristics largely reflected a pre-OBRA 81 reimbursement environment while this more current 1983 update reflects most of the changes States made to their provider reimbursement policies under the authority of OBRA 81 as of March, 1983.

Only nursing home, inpatient hospital, physician, outpatient hospital, free-standing clinics and prescription drug service reimbursement policies are included in this report. These services represent 85-90 percent of all Medicaid expenditures nationwide for the FY 82 period.

5.2 NURSING HOME REIMBURSEMENT

Expenditures for nursing home services is the largest and most rapidly growing component of national Medicaid outlays. From FY 81 through FY 82, Medicaid expenditures for nursing homes increased by approximately 11.3 percent; from $11.5 billion to $12.9 billion in FY 82. Growth in ICF-MR nursing expenditures was much higher than for the SNF and ICF homes. Most State Medicaid programs have departed from Medicare principles of reimbursement in favor of various forms of prospective reimbursement where rates and rate increases are negotiated or determined by formulas prior to each new fiscal year. The prospective methods are generally either facility specific negotiated rates or class rates based on type of facility, size, and location. Some States use a combination of methods. There are only 10 States that continue to use Medicare retrospective methods for SNFs.

Recent other initiatives to contain nursing home Medicaid expenditures include restrictions in licensed bed capacity, more stringent patient assessment protocols for entry into homes, and emphasis on home and community-based care settings as an alternative to expensive institutional care. (See Chapter 6 for a discussion of Section 2176 home and community-based care waivers).

5.2.1 Skilled Nursing Facilities (SNFs)

Skilled nursing facilities (SNFs) represented $4.4 billion of the $12.9 billion spent on nursing homes in FY 82, or about 34 percent. Table 5.1(A) shows the type of reimbursement system in use for SNFs by each reporting State. For each State, the table indicates the State fiscal year end and the type of reimbursement system classified according to: prospective, facility-specific; retrospective, facility-specific; prospective, class rates; or some combination of methods. The varying types of reimbursement systems do not, however, necessarily reflect differences in generosity with respect to SNF reimbursement since each State is free to define "allowable costs" and specify allowable rates of increases. In general, prospective class rates are thought to be more restrictive and encourage maximum competitiveness and cost-consciousness on the part of the nursing home industry. Rates may be determined on a "cost center" basis or on total cost (per diem) basis unique to each home or in relation to all homes in a bed size class for defined geographic areas.

Table 5.1(A) shows that 36 States, representing 80% of Medicaid SNF expenditures, use the prospective facility-specific or class rate method. This indicates that nearly three-quarters of the programs nationwide prefer to negotiate rates in advance of the year taking into account the unique operating characteristics of each facility. The Table also shows that 10 States use retrospective facility-specific rate determinations. This is typically a holdover from Medicare principles although more stringent guidelines on allowable cost principles could apply. The largest SNF programs in terms of total days of care (TDOC) tend to use prospective reimbursement methods. The five largest in FY 82 as shown in Table 5.1(B) were California, New York, Pennsylvania, Illinois, and Ohio. Of these larger programs, only Pennsylvania used the retrospective method. Ohio used a combination of prospective and retrospective methods. Only seven States reimbursed SNFs on a prospective class-rate basis, notably California. There were four States that reported use of a combination of these methods. During FY 82, the number of States using retrospective methods dropped from 13 to 10.

Table 5.1(A)

LONG-TERM CARE: SNF REIMBURSEMENT - 1983

STATE	Year End	REIMBURSEMENT SYSTEM: Prospective Facility Specific	Retrospective Facility Specific	Prospective Class-Rates	Combination
ALABAMA	9 30	X	-	-	-
ALASKA	6 30	-	X	-	-
ARKANSAS	6 30	-	-	X	-
CALIFORNIA	6 30	-	-	X	-
COLORADO	6 30	X	-	-	-
CONNECTICUT	6 30	X	-	-	-
DELAWARE	6 30	X	-	-	-
DIST COLUMBIA	9 30	X	-	-	-
FLORIDA	6 30	X	-	-	-
GEORGIA	12 31	X	-	-	-
HAWAII	9 30	-	X	-	-
IDAHO	6 30	X	-	-	-
ILLINOIS	6 30	X	-	-	-
INDIANA	6 30	X	-	-	-
IOWA	6 30	-	X	-	-
KANSAS	6 30	X	-	-	-
KENTUCKY	6 30	X	-	-	-
LOUISIANA	** **	-	-	X	-
MAINE	6 30	-	-	-	X
MARYLAND	6 30	-	X	-	-
MASSACHUSETTS	6 30	-	X	-	-
MICHIGAN	6 30	X	-	-	-
MINNESOTA	9 30	X	-	-	-
MISSISSIPPI	6 30	X	-	-	-
MISSOURI	6 30	X	-	-	-
MONTANA	6 30	X	-	-	-
NEBRASKA	6 30	X	-	-	-
NEVADA	6 30	-	-	-	X
NEW HAMPSHIRE	6 30	-	X	-	-
NEW JERSEY	6 30	X	-	-	-
NEW MEXICO	6 30	-	X	-	-
NEW YORK	9 30	-	-	X	-
N CAROLINA	6 30	X	-	-	-
N DAKOTA	6 30	-	-	-	X
OHIO	12 31	-	-	-	X
OKLAHOMA	12 31	X	-	-	-
OREGON	6 30	-	X	-	-
PENNSYLVANIA	6 30	-	X	-	-
RHODE ISLAND	6 30	X	-	-	-
S CAROLINA	12 31	X	-	-	-
S DAKOTA	6 30	X	-	-	-
TENNESSEE	6 30	-	X	-	-
TEXAS	8 31	-	-	X	-
UTAH	6 30	-	-	X	-
VERMONT	6 30	-	-	X	-
VIRGINIA	9 30	X	-	-	-
WASHINGTON	6 30	X	-	-	-
W VIRGINIA	6 30	X	-	-	-
WISCONSIN	6 30	X	-	-	-
WYOMING	6 30	X	-	-	-
TOTAL STATES		29	10	7	4
% TOTAL U.S. $ FOR CATEGORY		32.8	14.6	47.3	5.3

** Indicates Data Not Reported or Not Available

Table 5.1(B)

LONG-TERM CARE: SNF REIMBURSEMENT - 1983

STATE	MEDICAID USE, EXPENDITURE, AND RATE DATA: AVERAGE RATE PER PATIENT DAY ($) FY80	FY81	FY82	AVERAGE MEDICAID PAYMENT PER PATIENT DAY ($) FY80	FY81	FY82	TOTAL DAYS OF CARE (in thousands) FY80	FY81	FY82	ANCILLARY SERVICES INCLUDED IN PER DIEM RATE: PT	OT	Non-Legend Prescribed Drugs	Medical Supplies	Durable Equipment	Other
ALABAMA	29.33	30.79	37.61	NN	NN	24.43	NN	NN	521	-	-	X	-	X	X	-
ALASKA	93.45	97.39	NN	NN	NN	NN	1	4	NN	X	X	X	X	X	X	-
ARKANSAS	23.35	25.53	26.35	17.89	18.81	26.35	2,485	2,568	2,786	X	-	X	-	X	-	-
CALIFORNIA	35.27	36.10	NN	27.34	27.82	38.77	24,026	23,854	24,376	-	-	X	-	X	X	-
COLORADO	26.03	28.73	30.90	19.13	21.11	23.64	902	1,179	1,152	X	-	X	-	X	X	-
CONNECTICUT	37.11	41.49	NN	29.63	32.73	NN	4,914	5,125	NN	X	X	X	-	X	-	X
DELAWARE	34.31	44.28	NN	25.97	28.30	NN	13	17	NN	-	X	X	-	X	-	-
DIST COLUMBIA	66.93	65.90	NN	59.59	57.76	NN	38	34	NN	X	-	X	X	X	X	-
FLORIDA	31.29	NN	36.26	23.83	26.26	27.44	2,356	2,075	2,072	X	X	X	-	X	-	-
GEORGIA	25.93	28.63	28.20	20.40	22.20	20.21	3,201	3,310	3,156	X	X	X	-	X	X	-
HAWAII	62.11	71.56	NN	55.03	62.95	NN	388	313	NN	-	-	-	-	-	-	X
IDAHO	29.73	33.12	32.39	27.09	32.25	26.99	361	338	276	X	X	X	-	X	-	-
ILLINOIS	28.82	32.60	28.35	22.49	23.99	21.26	4,421	4,872	5,500	-	-	X	-	X	X	-
INDIANA	NN	NN	41.98	NN	NN	41.98	NN	NN	1,461	-	-	-	-	-	-	-
IOWA	25.56	35.62	59.69	32.06	43.51	59.69	27	30	36	X	X	X	X	X	X	X
KANSAS	25.48	27.80	NN	20.15	21.65	NN	116	124	NN	X	X	-	-	-	-	-
KENTUCKY	41.25	42.74	49.92	31.87	33.87	NN	693	723	NN	-	-	-	-	X	-	-
LOUISIANA	26.73	31.85	NN	20.91	24.89	NN	108	124	NN	X	-	X	-	X	X	X
MAINE	56.20	61.15	64.47	NN	53.12	38.19	53	52	66	X	-	X	-	X	-	-
MARYLAND	31.52	36.14	NN	24.29	27.63	NN	4,250	4,527	NN	X	X	X	-	X	X	X
MASSACHUSETTS	39.57	41.06	44.40	32.04	31.15	34.25	5,151	5,248	4,349	-	-	X	-	X	X	X
MICHIGAN	31.50	35.56	36.72	24.31	27.05	27.04	11,673	2,699	3,243	-	-	X	-	X	X	-
MINNESOTA	38.25	44.81	NN	NN	NN	NN	7,312	8,071	NN	-	-	X	X	X	X	-
MISSISSIPPI	25.59	28.79	31.32	22.11	23.30	25.96	2,379	2,012	1,780	X	-	-	-	X	X	-
MISSOURI	34.05	37.13	42.10	28.50	30.01	34.55	132	132	97	X	X	X	-	X	X	-
MONTANA	33.85	36.75	NN	21.22	24.10	NN	82	79	NN	-	-	-	-	X	X	-
NEBRASKA	35.45	38.22	44.64	29.88	31.07	34.61	204	187	185	-	-	-	-	-	-	-
NEVADA	37.72	40.25	48.26	31.27	32.65	39.04	26	30	32	-	-	X	-	X	-	X
NEW HAMPSHIRE	NN	NN	53.62	28.37	33.22	44.88	52	27	19	X	X	X	X	X	X	-
NEW JERSEY	43.05	46.13	51.91	34.57	36.36	41.04	404	452	479	-	-	X	-	X	-	X
NEW MEXICO	56.28	66.31	51.14	40.50	44.59	46.32	24	25	31	X	X	X	-	X	X	-
NEW YORK	62.68	67.63	78.70	NN	NN	61.43	18,308	18,550	20,588	X	X	X	X	X	-	X
N CAROLINA	34.19	41.40	46.73	28.90	34.81	36.85	1,855	2,011	2,109	X	X	X	X	X	X	-
N DAKOTA	31.91	36.33	40.85	24.46	30.51	33.10	642	662	697	X	X	X	-	X	X	-
OHIO	36.81	38.56	42.26	NN	NN	26.03	7,869	7,579	7,935	X	X	X	-	X	X	X
OKLAHOMA	26.00	29.00	30.00	NN	NN	NN	NN	NN	NN	-	-	-	-	-	-	-
OREGON	34.23	39.79	42.34	27.31	28.87	34.65	195	131	96	-	-	X	-	-	-	-
PENNSYLVANIA	NN	NN	42.26	29.06	33.93	42.20	10,187	10,752	9,225	X	X	X	-	X	-	-
RHODE ISLAND	40.85	47.32	43.48	32.82	37.24	31.53	68	57	67	X	X	X	-	X	-	X
S CAROLINA	39.84	44.25	42.99	29.43	31.76	NN	3,027	3,119	NN	X	X	X	-	X	-	-

Table 5.1(B) (Con't)

LONG-TERM CARE: SNF REIMBURSEMENT - 1983

STATE	MEDICAID USE, EXPENDITURE, AND RATE DATA: AVERAGE RATE PER PATIENT DAY ($) FY80	FY81	FY82	AVERAGE MEDICAID PAYMENT PER PATIENT DAY ($) FY80	FY81	FY82	TOTAL DAYS OF CARE (in thousands) FY80	FY81	FY82	ANCILLARY SERVICES INCLUDED IN PER DIEM RATE: PT	OT	Non-Legend Drugs	Prescribed Drugs	Medical Supplies	Durable Equipment	Other
S DAKOTA	23.33	26.36	38.08	17.79	19.74	21.97	150	150	102	X	X	X	X	X	X	-
TENNESSEE	36.20	40.50	NN	33.17	36.24	NN	235	306	NN	X	X	X	-	X	X	-
TEXAS	33.67	36.05	35.51	24.48	26.20	27.24	1,637	1,423	1,181	X	-	X	-	X	X	-
UTAH	36.52	39.32	NN	29.20	30.40	NN	316	225	NN	-	-	X	-	X	-	-
VERMONT	41.95	47.77	44.07	35.48	41.51	44.07	31	20	NN	X	X	X	-	X	X	-
VIRGINIA	46.43	51.26	61.90	41.98	45.47	53.15	227	276	189	X	X	X	-	X	X	-
WASHINGTON 1/	30.24	34.37	35.08	NN	26.00	25.51	16	16	6,000	-	-	X	-	X	-	-
W VIRGINIA 2/	33.79	36.80	44.39	NN	NN	36.98	NN	NN	523	X	X	X	-	X	X	-
WISCONSIN	38.00	42.00	NN	33.00	36.00	NN	6,500	6,900	NN	-	-	X	-	X	X	-
WYOMING	29.90	33.71	NN	20.04	23.14	NN	408	426	NN	X	X	X	-	X	-	-
TOTAL STATES										31	25	42	8	44	28	11
SIMPLE AVERAGE	37.49	41.71	42.88	28.94	32.24	34.89	2,771	2,627	3,135							

NN Indicates Data Not Reported or Not Available
1/ Days of care combined with ICF.
2/ Days of care combined for all facility types.

Table 5.1(B) contains data on average reimbursement rates per patient day (allowable by State Medicaid policy), average Medicaid payment per patient day (allowable charges minus patient contribution), and total days of care for State fiscal years 80, 81, and 82. In FY 82, the simple average Medicaid reimbursement rate per day for SNF services nationwide was $42.88 with rates ranging from a low of $26.35 in Arkansas to a high of $78.70 in New York (excluding Hawaii and Alaska). The national simple average Medicaid payment per patient day was $34.89, the lower rate reflecting mandatory patient contributions, primarily from SSI and Social Security payments to the recipient. Total days of care in FY 82 ranged from a low of 19,000 in New Hampshire to a high of 24,376,000 in California. Simple nationwide averages can be deceptive given the tremendous interstate differences in payment rate per recipient. For example, California and New York provide a much more accurate picture of trends in total SNF use and expenditures. Finally, Table 5.1(B) indicates the extent to which ancillary services are included in SNF per diem rates. Most States include non-legend drugs, medical supplies and durable medical equipment whereas only half include physical or occupational therapy and very few include prescription drugs in the per diem rate.

5.2.2 Intermediate Care Facilities (ICFs)

Intermediate care facilities (ICFs) accounted for $5.0 billion out of $12.9 billion spent on nursing homes in FY 82, or 39 percent. Although ICF services are optional, all states include this service in their benefit package. Table 5.1(C) shows the type of Medicaid reimbursement used by each reporting State. The trend toward prospective reimbursement methods for ICFs is even stronger than in the case of SNF reimbursement methods. Of the 50 reported States, 40 (representing 84% of national ICF expenditures) preferred this form of reimbursement. Only seven States reported use of the retrospective facility-specific method. There were three States which reported using a combination of methods.

Table 5.1(D) presents State data on ICF average Medicaid allowable rates per day, average payments per day, and total days of care. Both rates per patient day and payments per patient day reflect wide interstate variability. Excluding Alaska and Hawaii, average Medicaid allowable ICF rates per patient day for FY 82 ranged from a low of $25.75 in Arkansas to a high of at

Table 5.1(C)

LONG-TERM CARE: ICF REIMBURSEMENT - 1983

STATE	Year End	REIMBURSEMENT SYSTEM: Prospective Facility Specific	Retrospective Facility Specific	Prospective Class-Rates	Combination
ALABAMA	9 30	X	-	-	-
ALASKA	6 30	-	X	-	-
ARKANSAS	6 30	-	-	X	-
CALIFORNIA	6 30	-	-	X	-
COLORADO	6 30	X	-	-	-
CONNECTICUT	6 30	X	-	-	-
DELAWARE	6 30	X	-	-	-
DIST COLUMBIA.	9 30	X	-	-	-
FLORIDA	6 30	X	-	-	-
GEORGIA	12 31	X	-	-	-
HAWAII	9 30	-	X	-	-
IDAHO	6 30	X	-	-	-
ILLINOIS	6 30	X	-	-	-
INDIANA	6 30	X	-	-	-
IOWA	6 30	X	-	-	-
KANSAS	6 30	X	-	-	-
KENTUCKY	6 30	X	-	-	-
LOUISIANA	** **	-	-	X	-
MAINE	6 30	X	-	-	-
MARYLAND	6 30	-	X	-	-
MASSACHUSETTS	6 30	-	X	-	-
MICHIGAN	6 30	X	-	-	-
MINNESOTA	9 30	X	-	-	-
MISSISSIPPI	6 30	X	-	-	-
MISSOURI	6 30	X	-	-	-
MONTANA	6 30	X	-	-	-
NEBRASKA	6 30	X	-	-	-
NEVADA	6 30	-	-	-	X
NEW HAMPSHIRE	6 30	X	-	-	-
NEW JERSEY	6 30	X	-	-	-
NEW MEXICO	6 30	-	X	-	-
NEW YORK	9 30	-	-	X	-
N CAROLINA	6 30	X	-	-	-
N DAKOTA	6 30	-	-	-	X
OHIO	12 31	-	-	-	X
OKLAHOMA	12 31	X	-	-	-
OREGON	6 30	-	X	-	-
PENNSYLVANIA	6 30	-	X	-	-
RHODE ISLAND	6 30	X	-	-	-
S CAROLINA	12 31	X	-	-	-
S DAKOTA	6 30	X	-	-	-
TENNESSEE	6 30	X	-	-	-
TEXAS	8 31	-	-	X	-
UTAH	6 30	-	-	X	-
VERMONT	6 30	-	-	X	-
VIRGINIA	9 30	X	-	-	-
WASHINGTON	6 30	X	-	-	-
W VIRGINIA	6 30	X	-	-	-
WISCONSIN	6 30	X	-	-	-
WYOMING	6 30	X	-	-	-
TOTAL STATES		33	7	7	3
% TOTAL U.S. $ FOR CATEGORY		62.8	12.0	20.8	4.3

** Indicates Data Not Reported or Not Available

Table 5.1(D)

LONG-TERM CARE: ICF REIMBURSEMENT - 1983

STATE	MEDICAID USE, EXPENDITURE, AND RATE DATA: AVERAGE RATE PER PATIENT DAY ($) FY80	FY81	FY82	AVERAGE MEDICAID PAYMENT PER PATIENT DAY ($) FY80	FY81	FY82	TOTAL DAYS OF CARE (in thousands) FY80	FY81	FY82	ANCILLARY SERVICES INCLUDED IN PER DIEM RATE: PT	OT	Non-Legend Prescribed Drugs	Non-Legend Prescribed Drugs	Medical Supplies	Durable Equipment	Other
ALABAMA	22.04	24.20	25.81	22.75	22.63	22.69	5,461	5,718	4,895	-	-	X	-	X	X	-
ALASKA	93.45	97.39	104.26	NN	NN	98.09	4	4	159	X	X	X	X	X	X	-
ARKANSAS	22.45	24.65	25.75	18.16	19.53	25.75	3,077	3,168	3,153	X	-	X	-	X	-	-
CALIFORNIA	NN	28.90	NN	30.58	32.31	29.18	2,176	2,215	1,210	-	-	X	-	X	X	-
COLORADO	25.66	28.24	30.92	19.00	20.91	22.81	2,061	2,788	2,681	X	-	X	-	X	X	-
CONNECTICUT	24.16	26.57	NN	18.29	19.55	NN	922	949	NN	X	X	X	-	X	-	X
DELAWARE	34.31	44.28	NN	34.98	36.62	NN	371	434	NN	-	X	X	-	X	-	-
DIST COLUMBIA	50.55	50.87	NN	44.38	44.02	NN	299	383	NN	X	-	X	X	X	X	-
FLORIDA	28.48	NN	33.21	20.46	22.61	23.51	4,773	5,546	5,530	X	X	X	-	X	-	-
GEORGIA	23.56	26.17	25.94	18.78	20.58	19.49	5,552	5,521	5,412	X	X	X	-	X	X	-
HAWAII	49.34	58.18	NN	42.96	50.28	NN	307	420	NN	X	X	X	X	X	X	X
IDAHO	27.57	29.63	31.33	21.39	27.38	26.11	629	626	630	X	X	X	-	X	-	-
ILLINOIS	20.67	22.84	34.04	15.17	16.38	20.42	13,318	13,332	12,500	-	-	X	-	X	X	-
INDIANA	NN	NN	32.68	NN	NN	32.68	NN	NN	7,406	-	-	-	-	-	-	-
IOWA	22.15	24.00	25.89	15.90	16.75	17.57	5,700	5,800	5,734	X	X	X	X	X	X	X
KANSAS	19.99	22.16	NN	14.66	16.01	NN	4,210	4,297	NN	X	X	-	-	-	-	-
KENTUCKY	21.89	27.66	31.95	20.71	21.93	NN	3,356	3,806	NN	-	-	-	-	X	-	-
LOUISIANA	24.43	26.62	NN	18.93	20.58	NN	6,530	6,601	NN	X	-	X	-	X	X	X
MAINE	33.50	37.05	40.30	NN	29.15	22.23	2,510	2,438	460	X	-	X	-	X	-	-
MARYLAND	31.52	36.14	NN	24.29	27.63	NN	4,250	4,527	NN	X	X	X	-	X	X	X
MASSACHUSETTS	28.22	29.15	33.24	21.55	21.39	24.33	6,119	6,019	5,872	-	-	X	-	X	X	X
MICHIGAN	29.56	32.52	36.72	22.27	24.01	27.04	11,673	8,974	9,050	-	-	X	-	X	X	-
MINNESOTA	30.91	35.88	NN	NN	NN	NN	5,268	5,210	NN	-	-	X	X	X	X	-
MISSISSIPPI	21.33	24.97	29.12	20.15	22.09	23.69	1,355	1,821	2,198	X	-	-	-	X	X	-
MISSOURI 1/	26.82	29.64	32.53	21.35	23.03	24.98	4,696	5,378	5,668	X	X	X	-	X	X	-
MONTANA	33.85	36.75	NN	24.35	26.86	NN	1,277	1,355	NN	-	-	-	-	X	X	-
NEBRASKA	20.55	22.57	26.07	16.12	17.43	18.57	2,524	2,566	2,513	-	-	-	-	-	-	-
NEVADA	36.25	39.03	43.61	29.55	30.74	34.11	540	595	619	-	-	X	-	X	-	X
NEW HAMPSHIRE 2/	34.69	40.68	44.54	27.87	31.87	35.80	1,394	1,490	1,698	X	-	X	-	X	X	-
NEW JERSEY	36.38	39.48	43.81	28.75	30.49	33.57	6,585	6,670	6,740	-	-	X	-	X	-	X
NEW MEXICO	26.74	30.20	32.08	21.74	24.30	27.27	719	797	825	X	X	X	-	X	X	-
NEW YORK	39.66	42.74	49.21	NN	NN	36.00	7,280	7,335	6,908	X	X	X	X	X	-	X
N CAROLINA	26.82	29.91	33.49	21.59	23.62	25.33	3,073	3,281	3,301	X	X	X	X	X	X	-
N DAKOTA	23.56	27.35	30.00	17.94	21.99	23.20	544	583	636	X	X	X	-	X	X	-
OHIO	31.61	33.62	36.80	NN	NN	23.22	6,095	7,561	7,650	X	X	X	-	X	X	X
OKLAHOMA	22.50	28.00	26.53	NN	20.99	21.43	NN	6,206	6,189	-	-	-	-	-	-	-
OREGON	27.29	30.28	32.85	19.51	21.01	22.22	2,774	2,840	2,808	-	-	X	-	X	-	-
PENNSYLVANIA	NN	NN	37.62	27.61	33.88	36.35	4,436	4,591	5,367	X	X	X	-	X	-	-
RHODE ISLAND	30.60	34.99	38.95	23.79	26.95	29.66	2,079	2,105	2,177	X	X	X	-	X	-	X
S CAROLINA	30.04	33.28	32.05	29.43	31.76	NN	3,027	3,119	NN	X	X	X	-	X	-	-

Table 5.1(D) (Con't)

LONG-TERM CARE: ICF REIMBURSEMENT - 1983

STATE	MEDICAID USE, EXPENDITURE, AND RATE DATA									ANCILLARY SERVICES INCLUDED IN PER DIEM RATE						
	AVERAGE RATE PER PATIENT DAY ($)			AVERAGE MEDICAID PAYMENT PER PATIENT DAY ($)			TOTAL DAYS OF CARE (in thousands)									
	FY80	FY81	FY82	FY80	FY81	FY82	FY80	FY81	FY82	PI	OI	Non-Legend Drugs	Prescribed Drugs	Medical Supplies	Durable Equipment	Other
S DAKOTA	21.43	23.91	26.88	16.36	17.61	19.48	1,249	1,381	1,437	X	X	X	X	X	X	-
TENNESSEE	25.30	27.40	NN	19.58	20.32	NN	5,475	6,722	NN	X	X	X	-	X	X	-
TEXAS	26.06	27.61	26.79	17.69	18.66	19.19	21,993	21,667	20,681	X	-	X	-	X	X	-
UTAH	28.77	34.06	NN	22.56	26.24	NN	980	1,076	NN	-	-	X	-	X	-	-
VERMONT	32.45	35.65	44.07	25.85	27.85	44.07	719	743	NN	X	X	X	-	X	X	-
VIRGINIA	35.10	38.19	42.66	27.34	29.76	33.70	4,164	4,440	4,600	X	X	X	-	X	X	-
WASHINGTON 3/	30.24	34.37	NN	NN	26.00	NN	16	16	6,008	-	-	X	-	X	-	-
WEST VIRGINIA 4/	27.83	30.57	37.46	NN	NN	NN	NN	NN	523	X	X	X	-	X	X	-
WISCONSIN	29.00	32.00	NN	25.00	27.00	NN	6,700	7,000	NN	-	-	X	-	X	X	-
WYOMING	29.90	33.71	NN	20.04	23.14	NN	408	426	NN	X	X	X	-	X	-	-
TOTAL STATES										32	25	43	8	46	29	11
SIMPLE AVERAGE	30.20	33.49	35.98	23.16	25.31	28.60	3,801	3,970	4,507							

NN Indicates Data Not Reported or Not Available
1/ Rates are for community-based ICF-MR only.
2/ Days of care combined with ICF-MR.
3/ Days of care combined with SNF.
4/ Days of care combined for all facility types.

least $50.87 in the District of Columbia. Total days of care ranged from a low of 460 in Maine to a high of 20,500 in Texas. Patterns of inclusion of various ancillary services in the rates were about the same as that for SNFs.

The largest five ICF programs in FY 82 in terms of total days of care were Texas, Illinois, Michigan, Ohio, and Indiana. California reported a relatively small program. Average Medicaid reimbursement rates per patient day for ICFs tend to be about $35.98 per day, lower than for SNFs.

5.2.3 ICF - Mentally Retarded (ICF-MR)

ICF-MR expenditures in FY 82 accounted for $3.6 billion out of the $12.9 billion spent on nursing homes, or 28 percent. ICF-MR may be the smallest of the three types of nursing homes in terms of expenditures but it is the most expensive per recipient and fastest growing component of Medicaid long-term care outlays (21 percent growth in FY 82). Table 5.1(E) displays State preferences for reimbursing ICF-MR facilities. A relatively large number of States (14) use the typically more generous facility-specific retroactive method since many ICF-MR facilities are State-owned. These States account for 28 percent of total national ICF-MR expenditures. Only four States used prospective class rates for ICF-MRs. There were 28 States reporting use of facility-specific prospective rate-setting methods. States using strictly prospective methods (32) represented 66 percent of total national ICF-MR expenditures. Four States used a combination of methods. States using strictly prospective methods (32) represented 66 percent of total national ICF-MR expenditures.

Table 5.1(F) shows State average allowable Medicaid rates and payments per patient day. ICF-MR rates incorporate about the same ancillary services as do SNFs and ICFs. Note that ICF-MR rates run considerably higher than do rates for SNFs and ICFs. Institutional costs for these patients are higher due to the fact that patients often require greater intensity of care. The simple average allowable Medicaid rates per day in FY 82, excluding Alaska, was $83.20, ranged from a low of $44.24 in West Virginia to a high of $141.60 in Massachusetts. Average Medicaid payments per day were slightly lower. Total days of care ranged from a low of 27 in Missouri to a high of 4,534 in

Table 5.1(E)

LONG-TERM CARE: ICF-MR REIMBURSEMENT - 1983

STATE	Year End	REIMBURSEMENT SYSTEM: Prospective Facility Specific	Retrospective Facility Specific	Prospective Class-Rates	Combination
ALABAMA	9 30	X	-	-	-
ALASKA	6 30	-	X	-	-
ARKANSAS	6 30	X	-	-	-
CALIFORNIA	6 30	-	-	X	-
COLORADO	6 30	X	-	-	-
CONNECTICUT	6 30	X	-	-	-
DELAWARE	6 30	X	-	-	-
DIST COLUMBIA	9 30	X	-	-	-
FLORIDA	6 30	X	-	-	-
GEORGIA	12 31	X	-	-	-
HAWAII	9 30	-	X	-	-
IDAHO	6 30	X	-	-	-
ILLINOIS	6 30	X	-	-	-
INDIANA	6 30	X	-	-	-
IOWA	6 30	X	-	-	-
KANSAS	6 30	X	-	-	-
KENTUCKY	6 30	X	-	-	-
LOUISIANA	** **	X	-	-	-
MAINE	6 30	-	X	-	-
MARYLAND	6 30	-	X	-	-
MASSACHUSETTS 1/	6 30	-	-	-	X
MICHIGAN	6 30	-	X	-	-
MINNESOTA	9 30	-	X	-	-
MISSISSIPPI	6 30	X	-	-	-
MISSOURI	6 30	X	-	-	-
MONTANA	6 30	-	X	-	-
NEBRASKA	6 30	X	-	-	-
NEVADA	6 30	-	-	-	X
NEW HAMPSHIRE	6 30	X	-	-	-
NEW JERSEY 2/	6 30	-	X	-	-
NEW MEXICO	6 30	-	X	-	-
NEW YORK	9 30	-	-	X	-
N CAROLINA	6 30	X	-	-	-
N DAKOTA	6 30	-	-	-	X
OHIO	12 31	-	-	-	X
OKLAHOMA	12 31	X	-	-	-
OREGON	6 30	-	X	-	-
PENNSYLVANIA	6 30	-	X	-	-
RHODE ISLAND	6 30	-	X	-	-
S CAROLINA	12 31	-	X	-	-

Table 5.1(E) (Con't)

LONG-TERM CARE: ICF-MR REIMBURSEMENT - 1983

STATE	Year End	REIMBURSEMENT SYSTEM			
		Prospective Facility Specific	Retrospective Facility Specific	Prospective Class-Rates	Combination
S DAKOTA	6 30	X	-	-	-
TENNESSEE	6 30	X	-	-	-
TEXAS	8 31	-	-	X	-
UTAH	6 30	-	-	X	-
VERMONT	6 30	-	X	-	-
VIRGINIA	9 30	X	-	-	-
WASHINGTON	6 30	X	-	-	-
W VIRGINIA	6 30	X	-	-	-
WISCONSIN	6 30	X	-	-	-
WYOMING	6 30	X	-	-	-
TOTAL STATES		28	14	4	4
% TOTAL U.S. $ FOR CATEGORY		32.8	27.7	32.7	6.8

** Indicates Data Not Reported or Not Available
1/ ICF-MR/15 beds or less - individual facility prospective rate, ICF-MR > 15 beds reimbursed under Medicare formula.
2/ ICF-MR reimbursed under Medicare formula.

Table 5.1(F)

LONG-TERM CARE: ICF-MR REIMBURSEMENT - 1983

STATE	MEDICAID USE, EXPENDITURE, AND RATE DATA: AVERAGE RATE PER PATIENT DAY ($) FY80	FY81	FY82	AVERAGE MEDICAID PAYMENT PER PATIENT DAY ($) FY80	FY81	FY82	TOTAL DAYS OF CARE (in thousands) FY80	FY81	FY82	ANCILLARY SERVICES INCLUDED IN PER DIEM RATE: PI	OT	Non-legend Prescribed Drugs	Non-legend Drugs	Medical Supplies	Durable Equipment	Other
ALABAMA	74.20	94.10	105.08	NN	NN	77.95	NN	NN	391	-	-	X	-	X	X	-
ALASKA	153.00	167.00	197.33	NN	NN	194.66	1	1	137	X	X	X	X	X	X	-
ARKANSAS	36.54	64.55	73.00	32.23	55.42	63.00	560	523	510	X	-	X	-	X	-	-
CALIFORNIA	NN	NN	NN	30.58	32.31	NN	2,176	2,215	917	-	-	-	-	X	X	-
COLORADO	49.61	55.86	60.20	49.26	55.47	57.18	604	559	682	X	-	X	-	X	X	-
CONNECTICUT	NN	NN	NN	NN	NN	NN	NN	NN	NN	X	X	X	-	X	-	X
DELAWARE	43.49	48.46	NN	42.19	46.02	NN	154	161	NN	-	X	X	-	X	-	-
DIST COLUMBIA	66.23	65.63	NN	64.69	63.99	NN	143	87	NN	X	-	X	X	X	X	-
FLORIDA	NN	NN	77.18	51.96	58.05	74.93	487	519	745	X	X	X	-	X	-	-
GEORGIA	69.63	84.12	84.45	67.90	82.16	82.21	579	574	591	X	X	X	-	X	X	-
HAWAII	69.57	83.55	NN	67.91	81.41	NN	149	138	NN	-	-	-	-	-	-	X
IDAHO	50.38	73.49	86.65	50.17	72.77	86.65	143	148	168	X	X	X	-	X	-	-
ILLINOIS	21.42	24.62	82.75	18.11	20.78	62.06	938	946	2,344	-	-	X	-	X	X	-
INDIANA	NN	NN	53.69	NN	NN	53.69	NN	NN	649	-	-	-	-	-	-	-
IOWA	60.00	65.00	88.45	56.50	60.50	84.99	640	675	589	-	-	X	-	X	X	-
KANSAS	32.20	34.32	NN	26.87	28.17	NN	205	219	NN	X	X	-	-	-	-	-
KENTUCKY	52.29	70.97	75.00	59.00	65.42	NN	419	473	NN	-	-	-	-	X	-	-
LOUISIANA	42.18	56.00	NN	40.46	53.94	NN	784	992	NN	X	-	X	X	X	X	X
MAINE	NN	69.35	84.58	NN	66.85	64.33	NN	229	230	X	-	X	-	X	-	-
MARYLAND	96.72	114.95	NN	NN	NN	NN	578	630	NN	X	X	X	-	X	X	X
MASSACHUSETTS	111.00	123.00	141.60	110.80	122.00	140.60	1,100	1,000	656	X	X	X	-	-	-	X
MICHIGAN	NN	118.00	134.00	NN	NN	107.00	1,587	1,587	1,404	-	-	X	-	X	X	-
MINNESOTA	38.39	45.00	NN	NN	NN	NN	1,190	1,369	NN	-	-	X	X	X	X	-
MISSISSIPPI	35.35	38.94	41.39	35.10	36.08	39.96	259	304	444	X	-	-	-	X	X	-
MISSOURI 1/	58.44	71.84	NN	55.00	68.74	67.37	547	554	27	X	X	X	-	X	X	-
MONTANA	52.97	57.45	NN	22.54	30.17	NN	8	3	NN	-	-	-	-	X	X	-
NEBRASKA	47.03	55.20	71.49	44.19	57.34	66.60	331	287	320	-	-	-	-	-	-	-
NEVADA	62.39	76.65	93.14	61.02	74.84	91.06	58	58	59	-	-	X	-	X	-	X
NEW HAMPSHIRE	34.69	40.68	NN	27.87	31.87	NN	97	111	NN	X	-	X	-	X	X	-
NEW JERSEY	62.01	65.74	84.78	59.59	62.75	81.20	1,860	1,742	1,612	-	-	X	-	X	-	-
NEW MEXICO	57.71	59.66	69.27	43.80	55.59	67.13	143	152	176	X	X	X	-	X	X	-
NEW YORK	NN	NN	107.29	NN	NN	121.09	NN	NN	1,302	X	X	X	X	X	X	X
N CAROLINA	70.27	84.41	95.00	68.54	82.35	91.62	635	702	812	X	X	X	X	X	X	-
N DAKOTA	NN	NN	NN	NN	NN	NN	NN	NN	NN	X	X	X	-	X	X	-
OHIO	42.20	44.59	52.58	NN	NN	46.79	464	693	1,988	X	X	X	-	X	X	X
OKLAHOMA	46.15	60.00	55.36	NN	50.77	53.90	NN	651	630	-	-	-	-	-	-	-
OREGON	52.38	57.73	62.81	NN	NN	57.04	NN	NN	693	-	-	-	-	-	-	-
PENNSYLVANIA	NN	NN	135.26	87.03	98.94	111.88	2,415	2,653	2,642	X	X	X	-	X	-	-
RHODE ISLAND	35.36	50.15	99.99	31.90	46.26	95.95	59	73	313	X	X	X	-	X	-	X
S CAROLINA	53.08	54.75	57.81	43.84	46.03	NN	596	734	NN	X	X	X	-	X	-	-

LONG-TERM CARE: ICF-MR REIMBURSEMENT - 1983

STATE	MEDICAID USE, EXPENDITURE, AND RATE DATA: AVERAGE RATE PER PATIENT DAY ($) FY80	FY81	FY82	AVERAGE MEDICAID PAYMENT PER PATIENT DAY ($) FY80	FY81	FY82	TOTAL DAYS OF CARE (in thousands) FY80	FY81	FY82	ANCILLARY SERVICES INCLUDED IN PER DIEM RATE: PT	OT	Non-Legend Prescribed Drugs	Drugs	Medical Supplies	Durable Equipment	Other
S DAKOTA	NN	NN	56.54	45.38	51.02	55.00	239	232	266	X	X	X	X	X	X	-
TENNESSEE	NN	NN	NN	55.54	60.61	NN	731	817	NN	X	X	X	-	X	X	-
TEXAS	41.71	47.71	55.55	41.43	44.43	52.12	3,956	4,322	4,534	X	-	X	-	X	X	-
UTAH	41.64	48.22	NN	39.22	45.32	NN	438	427	NN	-	-	X	-	X	-	-
VERMONT	65.01	81.67	91.04	62.64	79.12	91.04	148	136	134	X	X	X	-	X	X	-
VIRGINIA	42.86	50.19	66.41	40.42	47.40	NN	1,341	1,489	1,110	X	X	X	-	X	X	-
WASHINGTON	30.24	34.37	61.60	NN	26.00	57.05	16	16	953	-	-	-	-	-	-	-
WEST VIRGINIA 2/	NN	NN	44.24	NN	NN	NN	NN	NN	523	X	X	X	-	X	X	-
WISCONSIN	55.00	61.00	NN	52.00	58.00	NN	800	800	NN	-	-	X	-	X	X	-
WYOMING	0.00	0.00	NN	0.00	0.00	NN	0	0	NN	-	-	-	-	-	-	-
TOTAL STATES										30	23	38	7	41	28	9
SIMPLE AVERAGE	55.50	66.64	83.20	49.56	57.27	79.87	689	714	865							

NN Indicates Data Not Reported or Not Available
1/ Community-based ICF-MR only.
2/ Days of care combined for all facility types.

Texas. Growth in patient loads, the high cost of an ICF-MR patient day, and relatively long lengths of stay work together to cause unusually rapid Medicaid expenditure growth for this component of State long-term care programs.

5.3 INPATIENT HOSPITAL SERVICES REIMBURSEMENT

Inpatient hospital services are the second largest component of Medicaid expenditures nationwide, accounting for $7.8 billion or 26 percent of Medicaid outlays in FY 82. From FY 81 to FY 82, inpatient hospital Medicaid expenditures rose from $7.2 billion to $7.8 billion, an increase of 9.1 percent. Prior to the Omnibus Budget Reconciliation Act of 1981, States were generally compelled to use Medicare reasonable cost-based reimbursement principles unless authorized by DHHS to adopt an alternative method.

The data shown in Table 5.2(A) reflect the post-OBRA environment. By early 1983, only 26 States (23% of national inpatient expenditures) still used the Medicare retrospective cost-based method. The other 24 States (77% of total inpatient expenditures) had moved to adopt either an alternative plan or an experimental system of inpatient reimbursement. States using experimental systems based on diagnostic-related groupings (DRGs) are New Jersey and Georgia. Most of the other States using alternative systems have tended toward facility-specific budget review, rate of increase control and forms of prospective rate-setting. Table 5.2(A) shows that among those States that had departed from Medicare principles by early 1982, only two had extended the method to private payers (Massachusetts and Rhode Island). The systems in Maryland and New Jersey encompass all payers. The dates for States using alternative methods represent the year in which the method was approved by DHHS and implemented. By early 1982 the method may have undergone modifications since its original approval. As a result of OBRA 81, many other States are expected to abandon inpatient Medicare reimbursement principles.

Between March of 1982 and March of 1983, the States of Iowa, District of Columbia, Nebraska, Pennsylvania, Vermont, Virginia and Washington altered their Medicare-based inpatient reimbursement systems to some form of prospec-

Table 5.2(A)

INPATIENT HOSPITAL REIMBURSEMENT: 1983

STATE	Year End	TYPES OF REIMBURSEMENT SYSTEMS: MEDICARE METHODS	ALTERNATIVE REIMBURSEMENT*: Medicaid Only	Plus Medicare	Plus Private	All Payers
ALABAMA	9-30	-	81	-	-	-
ALASKA	6-30	X	-	-	-	-
ARKANSAS	6-30	X	-	-	-	-
CALIFORNIA 1/	6-30	-	82	-	-	-
COLORADO	6-30	-	77	-	-	-
CONNECTICUT	6-30	X	-	-	-	-
DELAWARE	6-30	X	-	-	-	-
DIST COLUMBIA	9-30	X	-	-	-	-
FLORIDA	6-30	-	81	-	-	-
GEORGIA	9-30	-	83	-	-	-
HAWAII	6-30	X	-	-	-	-
IDAHO	6-30	-	80	-	-	-
ILLINOIS	6-30	-	83	-	-	-
INDIANA	6-30	X	-	-	-	-
IOWA	6-30	-	82	-	-	-
KANSAS	6-30	X	-	-	-	-
KENTUCKY	6-30	-	82	-	-	-
LOUISIANA	**-**	X	-	-	-	-
MAINE	6-30	X	-	-	-	-
MARYLAND 2/	6-30	-	-	-	-	77
MASSACHUSETTS 3/	6-30	-	-	-	82	-
MICHIGAN	9-30	-	80	-	-	-
MINNESOTA	9-30	X	-	-	-	-
MISSISSIPPI	6-30	-	81	-	-	-
MISSOURI	6-30	-	81	-	-	-
MONTANA	6-30	X	-	-	-	-
NEBRASKA	6-30	-	82	-	-	-
NEVADA	6-30	X	-	-	-	-
NEW HAMPSHIRE	6-30	X	-	-	-	-
NEW JERSEY	6-30	-	-	-	-	79
NEW MEXICO	6-30	X	-	-	-	-
NEW YORK	9-30	-	70	-	-	-
N CAROLINA	6-30	-	81	-	-	-
N DAKOTA	6-30	X	-	-	-	-
OHIO	6-30	X	-	-	-	-
OKLAHOMA	6-30	X	-	-	-	-
OREGON	6-30	X	-	-	-	-
PENNSYLVANIA 4/	6-30	-	82	-	-	-
RHODE ISLAND 5/	6-30	-	-	-	74	-
S CAROLINA	6-30	X	-	-	-	-

Table 5.2(A) (Con't)

INPATIENT HOSPITAL REIMBURSEMENT: 1983

STATE	Year End	TYPES OF REIMBURSEMENT SYSTEMS: MEDICARE METHODS	ALTERNATIVE REIMBURSEMENT*: Medicaid Only	Plus Medicare	Plus Private	All Payers
S DAKOTA	6-30	X	-	-	-	-
TENNESSEE	6-30	X	-	-	-	-
TEXAS	8-31	X	-	-	-	-
UTAH	6-30	X	-	-	-	-
VERMONT	6-30	-	82	-	-	-
VIRGINIA	9-30	-	82	-	-	-
WASHINGTON	6-30	-	82	-	-	-
W VIRGINIA	6-30	X	-	-	-	-
WISCONSIN	6-30	-	81	-	-	-
WYOMING	6-30	X	-	-	-	-
TOTAL STATES		26	20	0	2	2
% TOTAL U.S. $ FOR CATEGORY		22.6	66.7	0.0	6.3	4.4

* Alternative Systems Categorized By Groups Of Payers Covered; 4 Categories Include: Medicaid Only, Medicaid & Medicare, Medicaid & Private Payers, and All Payers.

** Data Not Reported or Not Available.

1/ Short-term only, excludes crossover claims, expenditure data for calendar year 1982. Selective contracting program not fully implemented in 1982.

2/ Per diem reimbursement based on approved hospital department rates. Payment made as percentage of predetermined charge rates.

3/ Not technically an all-payor system. Medicare does not participate in all-payor system for chronic hospitals. System is based on per diem rate of increase control.

4/ Cost-related with a maximum 10 percent cap on annual increases. Special treatment for high volume Medicaid hospitals. Going Medicaid-only DRG case rates in 1984.

5/ Prospective facility-specific subject to MAXICAP. State hospitals reimbursed using Medicare principles.

tive payment. Table 5.2(B) shows that most States opting for prospective inpatient methods pay on the basis of per diem and employ facility-specific rate of increase controls. Pennsylvania is in the process of converting its system from per diem-based rate of increase control over to DRG-based case rates. Other States are likely to follow during 1983 and 1984 as the Medicare PPS is phased in.

Table 5.2(C) shows recent trends in Medicaid inpatient hospital expenditures, total days of care per year, and the average payment per patient day. States having experience with alternative payment systems experienced less rapid expenditure growth. Total days of care actually went down between FY 80 and FY 82. The larger size Medicaid programs tended to adopt alternative payment systems, and experienced slower growth in per day inpatient payments in contrast to relatively smaller programs still adhering to Medicare principles. Interstate differentials in FY 82 average payment per inpatient day was tremendous. The rates ranged from a low of $139.22 in Texas to a high of $462.00 in California, with Alaska being the outlier at $485.32. Caution must be exercised in comparing growth rates among specific States as many factors other than reimbursement affect overall Medicaid hospital expenditures. The simple national average payment per inpatient day in FY 82 was $279.05, up 15 percent over FY 81.

5.4 PHYSICIAN SERVICES REIMBURSEMENT

Expenditures for physician services are the third largest component of Medicaid expenditures. In FY 82, physician services accounted for $2.1 billion, or 7.1 percent of Medicaid expenditures nationwide. States have broad discretion within general Federal guidelines regarding Medicaid reimbursement to physicians. Unlike Medicare, which uses the statutorily mandated customary, prevailing and reasonable (CPR) charge methodology, State Medicaid programs can use either the CPR method or a fee schedule approach; whichever is the lower. The Omnibus Budget Reconciliation Act of 1981 freed States from the CPR-based upper limit. States are now free to set physician Medicaid reimbursement payments at their discretion so long as they are "adequate and reasonable."

Table 5.2(B)

INPATIENT HOSPITAL REIMBURSEMENT: 1983

STATE	CHARACTERISTICS OF ALTERNATIVE SYSTEMS: Unit of Payment: Per Diem	Per Case	Capitation	Rate of Increase Control: Uniform	By Class	Individual	Other
ALABAMA	X	-	-	-	X	-	-
ALASKA							
ARKANSAS							
CALIFORNIA	X	-	-	-	-	X	-
COLORADO	X	-	-	-	-	X	-
CONNECTICUT							
DELAWARE							
DIST COLUMBIA							
FLORIDA	X	-	D	-	-	X	-
GEORGIA	-	X	-	-	-	-	X
HAWAII							
IDAHO	X	-	-	-	-	X	-
ILLINOIS	X	-	-	-	X	-	-
INDIANA							
IOWA	X	-	-	-	-	X	-
KANSAS							
KENTUCKY	X	-	-	-	X	-	-
LOUISIANA							
MAINE							
MARYLAND	X	-	-	-	-	X	-
MASSACHUSETTS	X	-	-	-	-	X	-
MICHIGAN	X	-	-	-	X	-	-
MINNESOTA							
MISSISSIPPI	X	-	-	-	X	-	-
MISSOURI	X	-	-	-	-	X	-
MONTANA							
NEBRASKA	X	-	-	-	-	X	-
NEVADA							
NEW HAMPSHIRE							
NEW JERSEY	-	X	D	-	-	X	-
NEW MEXICO							
NEW YORK	X	-	-	-	X	-	-
N CAROLINA	X	-	-	-	-	X	-
N DAKOTA							
OHIO							
OKLAHOMA							
OREGON							
PENNSYLVANIA	X	-	-	X	-	-	-
RHODE ISLAND	X	-	-	-	-	X	-
S CAROLINA							
S DAKOTA							
TENNESSEE							
TEXAS							
UTAH							
VERMONT	X	-	-	-	-	X	-
VIRGINIA	X	-	-	-	X	-	-
WASHINGTON	X	-	-	-	-	X	-
W VIRGINIA							
WISCONSIN	-	X	-	-	-	X	-
WYOMING							
TOTAL STATES	21	3	2	1	7	15	1
% TOTAL U.S. $ FOR CATEGORY	71.0	6.5	5.1	5.1	33.6	36.7	2.0

D Indicates Sub-State Demonstration Basis

Table 5.2(C)

INPATIENT HOSPITAL EXPENDITURES: 1983

STATE	MEDICAID USE, EXPENDITURE, AND RATE DATA								
	TOTAL EXPENDITURES ($ millions)			TOTAL DAYS OF CARE (in thousands)			AVERAGE PAYMENT PER INPATIENT DAY ($)		
	FY 80	FY 81	FY 82	FY 80	FY 81	FY 82	FY 80	FY 81	FY 82
ALABAMA	59.0	72.0	86.0	333	328	326	178.00	218.00	263.94
ALASKA	6.0	8.7	8.6	**	**	18	**	**	485.32
ARKANSAS	**	**	43.8	251	275	172	**	**	255.00
CALIFORNIA	958.8	1,181.0	1,654.1	6,820	6,750	3,578	140.59	174.96	462.00
COLORADO	31.4	38.8	46.4	153	155	167	204.71	249.89	277.75
CONNECTICUT	64.3	70.3	**	376	317	**	177.00	222.00	**
DELAWARE	12.1	12.9	**	40	37	**	**	**	**
DIST COLUMBIA	**	**	**	682	576	**	135.33	142.94	**
FLORIDA	120.9	143.5	117.6	642	641	651	188.31	223.87	272.00
GEORGIA	**	137.3	149.8	554	577	630	178.92	197.51	237.70
HAWAII	**	**	**	117	119	**	**	**	**
IDAHO	9.1	10.1	11.2	39	44	26	233.33	230.00	430.50
ILLINOIS	**	**	539.0	2,828	2,752	1,672	209.00	232.00	264.00
INDIANA	**	**	127.3	**	**	419	**	**	303.00
IOWA	**	**	62.5	223	383	345	**	**	181.36
KANSAS	51.3	59.6	**	301	308	**	170.49	193.37	**
KENTUCKY	75.4	98.8	114.0	379	432	403	199.15	228.34	282.00
LOUISIANA	**	**	**	443	362	**	**	**	**
MAINE	31.5	35.4	41.5	127	199	**	116.00	**	**
MARYLAND	132.3	128.9	128.9	472	417	400	280.10	309.04	322.38
MASSACHUSETTS	376.8	401.3	433.3	**	3,718	3,582	224.00	249.00	250.00
MICHIGAN	352.5	454.0	358.4	1,580	1,677	1,331	223.17	270.71	269.30
MINNESOTA	**	**	**	579	629	**	**	**	**
MISSISSIPPI	52.7	68.0	74.0	283	288	259	186.13	236.98	286.73
MISSOURI	**	**	122.4	440	516	502	**	**	243.99
MONTANA	11.2	14.3	**	46	62	**	**	**	**
NEBRASKA	**	**	27.5	177	186	198	**	**	139.22
NEVADA	11.4	18.2	22.9	73	92	94	**	**	243.50
NEW HAMPSHIRE	11.1	11.8	11.7	55	54	42	203.00	218.00	256.98
NEW JERSEY	172.0	191.0	247.1	1,431	1,307	1,253	120.00	146.00	173.25
NEW MEXICO	20.9	27.1	28.8	94	109	96	222.15	247.94	301.21
NEW YORK	**	1,461.0	1,456.0	4,250	**	5,107	**	**	285.07
N CAROLINA	102.0	123.0	125.7	563	565	811	112.78	131.92	155.04
N DAKOTA	**	**	12.0	55	58	49	**	**	245.00
OHIO	**	**	366.8	945	1,004	1,085	**	**	338.04
OKLAHOMA	67.3	95.9	114.0	364	433	465	185.13	221.62	245.00
OREGON	**	**	33.0	147	137	145	**	**	228.03
PENNSYLVANIA	550.6	630.0	560.9	2,022	1,956	2,168	177.14	214.36	275.01
RHODE ISLAND	22.0	20.2	25.0	98	91	87	224.42	221.67	291.03
S CAROLINA	47.5	57.0	63.0	247	254	189	192.43	224.45	334.00
S DAKOTA	**	**	14.0	54	52	56	136.46	157.25	262.36
TENNESSEE	84.6	97.9	**	430	504	**	196.95	194.05	**
TEXAS	172.2	206.3	221.2	1,689	1,620	776	96.86	129.06	284.94
UTAH	17.1	21.0	22.5	70	73	73	246.30	286.04	302.00
VERMONT	**	**	12.0	48	55	55	**	**	218.00
VIRGINIA	80.0	92.0	123.0	431	402	420	185.26	229.90	293.83
WASHINGTON	83.3	89.7	115.0	339	372	398	246.00	241.00	288.63
W VIRGINIA	**	**	55.0	**	**	201	**	**	273.05
WISCONSIN	106.2	111.9	128.0	376	367	353	282.62	305.28	362.00
WYOMING	**	**	**	10	10	**	**	**	**
TOTAL STATES	3,893	6,189	7,904	31,676	31,263	28,602			
SIMPLE AVERAGE							165.00	189.41	279.06

** Data Not Reported or Not Available.

The CPR method used by Medicare limits reimbursement to the lowest of the following: a physician's actual charge, the physician's median charge in a recent prior period (customary), or the 75th percentile of charges in that same period (prevailing). Any prevailing charges at or under the 75th percentile criterion are considered "reasonable". In some States, the 75th percentile is determined on the basis of physicians' charges in the same specialty and/or sub-State region; in others, States use charge data from all physicians regardless of specialty or sub-State region. Finally, since 1976 an "economic index" has been applied to limit the rate of increases in Medicare prevailing rates. Technically, Medicaid regulations refer to a "usual, customary and reasonable" (UCR) method. Other than confusion over definitions, the (UCR) method and the (CPR) methods are the same.5/ Within this framework, State Medicaid programs set physician reimbursement rates using the Medicare method or a fee schedule, whichever is the lower. Some States have delayed in updating physician charge profiles, use artificially low economic indices, or simply elect to reimburse at below Medicare's 75th percentile of prevailing to the point where they have, in reality, converted to a fee schedule.

Table 5.3(A) shows that by early 1983, 20 States reported using Medicare's CPR methods, although 5 of these States reimbursed physicians at below Medicare's 75th percentile of prevailing charges. These States represented only 29 percent of total physician expenditures. Thirty States reported using fee schedules, (71% of total physician expenditures) five of which use a relative value scale. Between March 1982 and March 1983, Georgia, Montana and Nebraska left Medicare principles for fee schedules. South Dakota left a fee schedule to return to Medicare principles. Eight States were experimenting with capitation reimbursement methods.

Table 5.3(B) shows the extreme interstate variations in physician reimbursement rates for GPs and specialists for a few selected procedures. The variaiton for a GP brief office exam (CPT-4, 90040) ranges from a low of $4.00

5/ Spitz, Bruce, State Guide to Medicaid Cost Containment, National Governors' Association and Intergovernmental Health Policy Project, September 1981.

Table 5.3(A)

PHYSICIAN SERVICES REIMBURSEMENT

STATE	TYPE OF REIMBURSEMENT SYSTEM: MEDICARE PERCENTILE OF PREVAILING	FEE SCHEDULES: FIXED FEE SCHEDULE	FEE SCHEDULES: RELATIVE VALUE SCALE	FEE SCHEDULES: CAPITATION	DATE OF LAST UPDATE
ALABAMA	<75%	-	-	-	
ALASKA	80%	-	-	-	-
ARKANSAS	<75%	-	-	-	-
CALIFORNIA	-	-	X	D	1 83
COLORADO	-	-	X	-	5 82
CONNECTICUT	-	X	-	-	-
DELAWARE	75%	-	-	-	*
DIST COLUMBIA	75%	-	-	-	*
FLORIDA	-	-	X	D	-
GEORGIA	-	X	-	-	11 81
HAWAII	75%	-	-	-	*
IDAHO	-	X	-	-	*
ILLINOIS	-	X	-	-	3 81
INDIANA	75%	-	-	-	7 82
IOWA	75%	-	-	-	7 82
KANSAS	75%	-	-	-	-
KENTUCKY	75%	-	-	D	-
LOUISIANA	75%	-	-	-	-
MAINE	-	X	-	-	8 77
MARYLAND	-	X	-	-	N/A
MASSACHUSETTS	-	X	-	-	4 81
MICHIGAN	-	X	-	D	12 80
MINNESOTA	<75%	-	-	-	-
MISSISSIPPI	-	X	-	-	7 82
MISSOURI	-	X	-	D	8 79
MONTANA	-	X	-	-	N/A
NEBRASKA	-	X	-	-	7 82
NEVADA	-	X	-	-	7 80
NEW HAMPSHIRE	-	X	-	-	*
NEW JERSEY	-	X	-	D	8 79
NEW MEXICO	75%	-	-	-	-
NEW YORK	-	X	-	D	8 80
N CAROLINA	-	X	-	-	1 82
N DAKOTA	-	X	-	-	6 81
OHIO	<75%	-	-	-	-
OKLAHOMA	75%	-	-	-	-
OREGON	75%	-	-	-	-
PENNSYLVANIA	-	X	-	D	11 81
RHODE ISLAND	-	X	-	-	9 80
S CAROLINA	-	X	-	-	5 82
S DAKOTA	75%	-	-	-	-
TENNESSEE	<75%	-	-	-	-
TEXAS	75%	-	-	-	-
UTAH	-	-	X	-	9 82
VERMONT	-	X	-	-	6 82
VIRGINIA	-	X	-	-	6 81
WASHINGTON	-	-	X	-	*
W VIRGINIA	-	X	-	-	*
WISCONSIN	-	X	-	-	*
WYOMING	75%	-	-	-	-
TOTAL STATES	20	25	5	8	
% TOTAL U.S. $ FOR CATEGORY	28.9	42.2	28.9		

* Indicates Data Not Reported or Not Available
D Indicates Sub-State demonstration basis

Table 5.3(B)

PHYSICIAN SERVICES REIMBURSEMENT: 1983*

	Maximum Allowable Physician Fees By Selected Procedures, Physician Type**					
	Brief Office Exam		Appendectomy		Obstetrical Care	
STATE	GP	Specialist	GP	Specialist	GP	Specialist
ALABAMA	$11.70	$11.70	$405.00	$405.00	$450.00	$450.00
ALASKA	$23.00	$24.47	$365.72	$715.08	$479.47	$422.54
ARKANSAS	$9.20	$9.20	$300.00	$306.60	$500.00	$500.00
CALIFORNIA	$12.00	$12.00	$312.00	$312.00	$458.00	$458.00
COLORADO	$11.25	$11.25	$267.50	$267.50	$374.50	$374.50
CONNECTICUT	$6.75	$6.75	$240.00	$240.00	$289.80	$289.80
DELAWARE	$12.00	$12.00	$370.00	$370.00	$435.00	$435.00
DIST COLUMBIA	$20.00	***	***	***	***	***
FLORIDA	$10.00	$10.00	$197.60	$197.60	$310.08	$310.08
GEORGIA	$12.36	$12.36	$329.60	$329.60	$339.90	$339.90
HAWAII	$14.31	$17.49	$400.00	$435.66	$326.39	$416.54
IDAHO	$10.50	$10.50	$336.40	$336.40	$450.00	$450.00
ILLINOIS	$10.50	$10.50	$250.00	$250.00	$375.00	$375.00
INDIANA	$13.60	$15.60	$312.00	$600.00	$461.90	$487.25
IOWA	$12.00	$18.00	$280.00	$475.66	$318.00	$413.17
KANSAS	$7.00	$7.00	$268.00	$268.00	$331.60	$331.60
KENTUCKY	$10.50	$12.00	$401.60	$401.60	$359.90	$409.90
LOUISIANA	$11.60	$13.10	$438.16	$500.00	$395.80	$550.00
MAINE	$8.00	$8.00	$217.50	$217.50	$268.00	$268.00
MARYLAND	$10.00	$10.00	$191.00	$191.00	$298.00	$298.00
MASSACHUSETTS	$4.00	$4.00	$224.50	$224.50	$168.00	$168.00
MICHIGAN	$7.00	$7.00	$258.60	$258.60	$372.72	$372.72
MINNESOTA	$12.10	$12.10	$370.00	$370.00	$350.00	$350.00
MISSISSIPPI	$4.00	$4.00	$225.00	$225.00	$315.00	$315.00
MISSOURI	$10.00	$10.00	$220.00	$220.00	***	***
MONTANA	$10.27	$10.27	$311.70	$311.70	$524.98	$524.98
NEBRASKA	$10.00	$14.10	$350.00	$393.80	$444.60	$500.00
NEVADA	$13.16	$13.16	$512.89	$512.89	$539.42	$539.42
NEW HAMPSHIRE	$6.00	$6.00	$225.00	$225.00	$214.00	$214.00
NEW JERSEY	$7.00	$9.00	$184.00	$211.00	$210.00	$236.00
NEW MEXICO	$10.40	$11.90	$367.75	$400.60	$305.85	$354.78
NEW YORK	$7.00	$9.00	$160.00	$160.00	$200.00	$275.00
N CAROLINA	$11.40	$13.10	$378.00	$378.00	$400.00	$454.75
N DAKOTA	$9.90	$9.90	$397.70	$397.70	$336.00	$336.00
OHIO	***	***	$225.00	$225.00	***	***
OKLAHOMA	$11.75	$15.60	$487.20	$487.20	$750.00	$750.00
OREGON	$9.85	$9.85	$344.95	$344.95	$446.25	$446.25
PENNSYLVANIA	$11.00	$11.00	$100.00	$100.00	$100.00	$100.00
RHODE ISLAND	$12.00	$12.00	$186.00	$186.00	$300.00	$300.00
S CAROLINA	$6.30	$6.30	$307.40	$307.40	$323.30	$323.30
S DAKOTA	$10.00	$10.00	$345.00	$345.00	$325.00	$325.00
TENNESSEE	$9.00	$12.60	$398.70	$451.90	$383.90	$461.80
TEXAS	$11.03	***	$368.05	***	$381.53	***
UTAH	$10.04	$11.01	$312.63	$382.58	$401.00	$524.50
VERMONT	$6.00	$6.00	***	***	$275.00	$275.00
VIRGINIA	$6.30	$6.30	$236.25	$236.25	$262.50	$262.50
WASHINGTON	$12.84	$12.84	$283.16	$283.16	$473.55	$473.55
W VIRGINIA	$10.00	$10.00	$230.00	$230.00	$255.00	$255.00
WISCONSIN	$15.00	$15.00	$400.00	$400.00	$530.00	$530.00
WYOMING	$10.80	$12.50	$358.10	$399.00	$358.00	$447.50
SIMPLE AVERAGE	$10.42	$10.99	$305.20	$329.50	$365.25	$384.66

* For States Not Reporting 1983 Rates, 1982 Rates Are Used as Reported Last Year

** Statewide Average Fees; Procedure Types by CPT-4 Codes: 90040 Brief Office Visit Exam, Evaluation/Treatment-Established Patient; 44950 Appendectomy; 59400 Total Obstetrical Care Including Antepartum Care, Vaginal Delivery, Post-Partum Care.

*** Indicates Data Not Reported or Not Available.

in Massachusetts and Mississippi to a high of $20.00 in the District of Columbia (excluding Alaska). The nationwide simple average for 1983 was $10.42. States using fee schedules are associated with rates less generous than Medicare.6/ For example, Pennsylvania, New York and New Jersey pay less than half of Medicare prevailing charges. The ratio of Medicaid to Medicare fees for general practitioners in New Jersey is only 0.38, the lowest in the country. Fourteen States recognize individual specialties for reimbursement purposes, many of which are Medicare CPR States.

To further indicate interstate variability among physician Medicaid reimbursement rates, Table 5.3(B) shows rates for the surgical procedure - appendectomy (CPT-4, 44950) and for total obstetrical care including antepartum care, vaginal delivery and post-partum care (CPT-4, 59400). For GP appendectomies, payment rates range from a low of $100.00 in Pennsylvania to $512.89 in Nevada; the simple national average being $305.20. GP reimbursement for total obstetrical care ranged from a low of $100.00 in Pennsylvania to a high of $750.00 in Oklahoma; the simple national average being $365.25. These interstate differences are summarized below:

Fee Variations	Office Visit (CPT-4 (90040)	Appendectomy CPT-4 (44950)	Obstetrical Care CPT-4 (59400)
High	$20.00 (DC)	$512.89 (NV)	$750.00 (OK)
Low	$ 4.00 (MA, MS)	$100.00 (PA)	$100.00 (PA)
Difference	$16.00	$412.89	$650.00
Simple Average	$10.42	$305.20	$365.25

There are many factors which could account for such wide interstate physician payment differences. For States using the CPR method, prevailing

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6/ Cromwell and Mitchell, Origins and Impacts Medicaid Reimbursement and Eligibility Policies on Physician Participation, October 1981, HCFA Contract Number 500-78-0051.

physician fees among various parts of the country account for much of the difference. For those using fee schedules, policy decisions were made to reimburse at rates often lower than Medicare prevailing rates. Lower physician reimbursement levels are not necessarily a way to help contain Medicaid costs. They tend to reduce physician participation in the program and often result in reduced recipient access to routine primary care. This can cause recipient substitution to more expensive care settings (e.g., emergency room and hospital outpatient departments). Low office reimbursement rates give a physician an incentive to hospitalize in order to gain higher fees for the same services that could have been performed in the office. Low rates may also lead to overuse of ancillary services. Low physician reimbursement rates may well be a false economy.

5.5 OUTPATIENT HOSPITAL, CLINIC AND DRUGS REIMBURSEMENT

Outpatient hospital services refer to emergency rooms and hospital-based ambulatory care clinics. "Clinics" refer to free-standing physician-supervised ambulatory care settings; this excludes rural health clinics. Drugs refer to legend or prescription drugs prescribed by a physician.

Table 5.4 shows that 27 of the reporting States (only 23 percent of national outpatient expenditures) use Medicare cost-based reimbursement principles for outpatient hospital services and 23 (77 percent of total expenditures) use alternate methods, normally fee schedules. Federal regulations specify only that Medicaid payments for outpatient hosptal services cannot exceed charges to Medicare. Below this ceiling, rates can be altered downward to reflect local conditions and preferences. There is flexibility to differentiate rates among emergency room care, specialized outpatient services, and primary care services. As with inpatient care, the trend has been for more and more States to abandon Medicare principles to reimburse outpatient hospital services in favor of alternate methods. Four States reported no coverage for free-standing clinic services. Seven States reported adherence to Medicare principles. There were 37 States using alternate methods (these 37 States represented 93 percent of national Medicaid clinic services expenditures).

Table 5.4

OUTPATIENT HOSPITAL AND CLINIC REIMBURSEMENT: 1983

STATE	OUTPATIENT HOSPITAL SERVICES		CLINIC SERVICES	
	Medicare Principles	Other	Medicare Principles	Other
ALABAMA	X	-	NC	NC
ALASKA	X	-	-	X
ARKANSAS	-	X	-	X
CALIFORNIA	-	X	-	X
COLORADO	X	-	-	X
CONNECTICUT	-	X	-	X
DELAWARE	X	-	-	X
DIST COLUMBIA	-	X	-	X
FLORIDA	-	X	**	**
GEORGIA	X	-	-	X
HAWAII	-	X	-	X
IDAHO	X	-	-	X
ILLINOIS	-	X	-	X
INDIANA	-	X	-	X
IOWA	X	-	-	X
KANSAS	X	-	X	-
KENTUCKY	X	-	X	-
LOUISIANA	X	-	**	**
MAINE	X	-	-	X
MARYLAND	-	X	-	X
MASSACHUSETTS	-	X	-	X
MICHIGAN	-	X	-	X
MINNESOTA	X	-	X	-
MISSISSIPPI	X	-	X	-
MISSOURI	-	X	-	X
MONTANA	X	-	-	X
NEBRASKA	-	X	-	X
NEVADA	-	X	-	X
NEW HAMPSHIRE	X	-	-	X
NEW JERSEY	-	X	-	X
NEW MEXICO	X	-	-	X
NEW YORK	-	X	-	X
N CAROLINA	X	-	-	X
N DAKOTA	X	-	X	-
OHIO	X	-	-	X
OKLAHOMA	-	X	-	X
OREGON	X	-	X	-
PENNSYLVANIA	-	X	-	X
RHODE ISLAND	-	X	NC	NC
S CAROLINA	-	X	-	X
S DAKOTA	X	-	-	X
TENNESSEE	X	-	-	X
TEXAS	X	-	NC	NC
UTAH	X	-	-	X
VERMONT	X	-	NC	NC
VIRGINIA	X	-	-	X
WASHINGTON	-	X	-	X
W VIRGINIA	-	X	-	X
WISCONSIN	-	X	-	X
WYOMING	X	-	X	-
TOTAL STATES	27	23	7	37
% TOTAL U.S. $ FOR CATEGORY	23.0	77.0	4.1	93.4

** Indicates Data Not Available or Not Reported;
NC Indicates Service Not Covered.

Prescription drug reimbursement conforms to the maximum alalowable cost (MAC) system in effect since 1976. This has lead to considerable uniformity in drug-specific payments across States, however, States vary in retail pharmacy dispensing fees, recipient copayments, limitations on use, over-the-counter exclusions and formulary status for legend drugs. Table 5.5 shows these interstate variations. For example, retail pharmacy dispensing fees (per prescription) range from a low of $2.25 in Pennsylvania to a high of $5.00 in Minnesota. Of the 48 States sponsoring a drug program, 30 charge no copayments; the remainder charge copayments to recipients ranging from $.25 to $10.99, most having copayments of $.50 to $1.00 per prescription. Between March 1982 and March 1983, five States dropped drug copayments entirely (Arkansas, Georgia, Idaho, Maryland and Mississippi). New Hampshire started a drug copayment policy and several other States made up and downward adjustments to drug copayment levels. Eight States limit number of new prescriptions per month. Eighteen States use a formulary (limited or restricted drug list).

Table 5 5

PRESCRIPTION DRUG REIMBURSEMENT: 1983

STATE	DRUGS: Retail Pharmacy Dispensing Fee(Range)	Copayment $ Range	Prescription Limits per month	Refills per Month(s)	$ Limit Per Month	Maximum Quantity (Days)	OTC* Exclusions	Formulary Status** (legend drug)
ALABAMA	$2.75	$0.50-$3.00	-	5 6	-	34 -	B	C
ALASKA	----------	----------	NO	DRUG	PROGRAM	----------	A	----------
ARKANSAS	$3.58	$0.00	4	5 6	-	33 -	B	B
CALIFORNIA	$3.60	$0.00	-	- -	-	100 -	B	D
COLORADO	$3.40	$0.00	-	- 1	-	100 -	B	C
CONNECTICUT	$3.11	$0.00	-	- -	-	30 90	B	B
DELAWARE	$3.03	$0.00	-	- -	-	- -	B	B
DIST COLUMBIA	$3.02	$0.50	-	3 4	-	- -	B	C
FLORIDA	$3.33	$0.00	-	- 12	22	- -	B	B
GEORGIA	$3.61	$0.00	-	- -	-	30 -	B	B
HAWAII	$3.22	$0.00	-	- -	-	- -	A	B
IDAHO	$2.50 -$3.50	$0.00	-	- -	30	34 -	B	B
ILLINOIS	$3.00	$0.00	-	- -	-	- -	B	D
INDIANA	$2.50	$0.00	-	- -	-	- -	A	A
IOWA	$3.35	$0.50	-	- -	-	- -	B	B
KANSAS	$3.87	$0.50	-	- 12	-	30 100	A	A
KENTUCKY	$2.35	$0.00	-	5 6	-	- -	B	C
LOUISIANA	$3.67	$0.00	-	5 6	-	- -	B	B
MAINE	$3.20	$0.50	-	5 6	-	180 -	B	B
MARYLAND	$3.25	$0.00	-	2 -	-	100 -	B	B
MASSACHUSETTS	$2.90	$0.00	-	5 6	-	180 -	B	B
MICHIGAN	$2.65	$0.50	-	- -	-	- -	B	C
MINNESOTA	$5.00	$0.00	-	5 6	-	30 100	A	A
MISSISSIPPI	$3.17	$0.00	6	6 1	-	- -	B	C
MISSOURI	$2.50	$0.50-$0.99	-	- -	-	34 90	B	C
MONTANA	$3.75	$0.50-$2.00	-	- -	-	- -	B	B
NEBRASKA	$4.35	$0.00	-	- -	-	- -	B	C
NEVADA	$3.78	$1.00	3	- -	-	30 100	B	B
NEW HAMPSHIRE	$2.70	$1.00	-	5 6	-	90 -	A	B
NEW JERSEY	$2.50 -$2.80	$0.00	-	5 6	-	60 -	A	B
NEW MEXICO	$3.15	$0.25	-	- -	-	180 -	B	C
NEW YORK	$2.60	$0.00	-	5 6	-	- -	B	D
N CAROLINA	$3.00	$0.50	6	- -	-	- -	B	A
N DAKOTA	$3.57	$0.00	-	5 12	-	- -	A	B
OHIO	$2.60	$0.00	-	5 -	-	34 -	B	A
OKLAHOMA	$3.55	$0.00	3	5 6	-	34 -	B	C
OREGON	$3.27	$0.00	-	5 -	-	- 100	B	D
PENNSYLVANIA	$2.25	$0.00	-	5 6	15	34 100	A	B
RHODE ISLAND	$3.10	$0.00	-	3 -	-	30 100	A	B
S CAROLINA	$3.03	$0.50-$0.03	3	- -	-	- 90	B	C
S DAKOTA	$3.00	$1.00	-	- -	-	- -	B	B
TENNESSEE	$2.75	$0.00	-	7 1	-	- -	B	C
TEXAS	$3.50	$0.00	3	5 6	-	180 -	B	B
UTAH	$2.80	$0.00	-	- -	-	30 100	B	-
VERMONT	$2.50	$0.50	-	5 -	-	30 -	B	A
VIRGINIA	$2.85	$0.50-$1.00	-	- -	-	- -	B	B
WASHINGTON	$2.89 -$3.25	$0.00	-	- -	-	- -	B	C
W VIRGINIA	$2.75	$0.50-$1.00	-	5 -	-	30 -	B	C
WISCONSIN	$3.40	$0.50	12	11 12	-	34 -	B	C
WYOMING	----------	----------	NO	DRUG	PROGRAM	----------	----------	----------

* A = All or Most OTC Drugs Reimburseable; B = Few or No OTC Drugs Reimburseable Except Insulin.
** A-No Drug List-All Legend Drugs Reimburseable; B-No Drug List But Certain Categories Excluded Fr Reimbursement; C-Limited Drug List; D-Restricted Drug List.

6. ADMINISTRATION AND FINANCE

This section discusses the administration of State Medicaid programs, activities associated with the administration of the programs, and data concerning the finance and data management systems.

6.1 ADMINISTRATION

Administration of the State Medicaid program is vested in single State agencies. Within each agency, State plans must designate a medical assistance unit responsible for developing, analyzing, and evaluating the Medicaid program. The law further requires the States to establish medical care advisory committees to advise the Medicaid agency director about health and medical services. This committee must include board certified physicians and other representatives of the health professions, members of consumer groups, and the director of either the State public welfare or the public health department (whichever department does not run the Medicaid agency).

Activities for administering the State Medicaid program are discussed in this section and include: program administration, Medicaid Management Information System (MMIS), claims processing activity, State administration, and waivers.

6.1.1 Medicaid Eligibility Determination, Program Administration, and Administering Agency

States are allowed three options for administering coverage of SSI recipients (42 CFR Sec.431.10(c)):

- States electing to extend Medicaid to all SSI recipients can enter into an agreement with the Social Security Administration under Section 1634 of the Act for determinations of Medicaid eligibility;
- States electing to extend Medicaid eligibility to recipients of SSI can maintain eligibility determinations on a State level; or
- States electing the 209(b) option (where recipients of cash assistance under SSI are not automatically eligible for Medicaid) can require cash assistance recipients to make a separate application for Medicaid.

Table 6.1.1 displays the option chosen by each State. Thirty States elected to have Federal determination and those 30 States expended 75.5 percent of the total Medicaid expenditures in 1982. Six States elected to extend Medicaid to all recipients of SSI but maintain eligibility determination on a State level. Those six States (AL, ID, KA, MS, NV, OR) expended only 3.5 percent of the total Medicaid expenditures in 1982. Fourteen States elected the 209(b) option and expended 21.0 percent of the total Medicaid expenditures in 1982.

A State plan must be in operation Statewide through a system of local offices under equitable standards for assistance and administration that are mandatory throughout the State (42 CFR Sec.431.50(b)). However, the State may choose to administer the program on the State level or by political subdivision of the State. Table 6.1.1 displays the choices made by States as to the level on which the program will be administered. Forty-two States have chosen to administer the Medicaid program on a State level and accounted for 60.9 percent of the total Medicaid expenditures in 1982. Eight States (CA, MN, NE, NY, NC, ND, OH, and SC) have chosen local administration and those eight States accounted for 39.1 percent of the total Medicaid expenditures in 1982. What this means is that in these States if the program is locally administered, the State plan is mandatory on each of the political subdivisions. The local administrations do not have the authority to change or disapprove any administrative decision of the State Medicaid agency with respect to the application of policies rules, and regulations issued by the Medicaid agency.

A State plan must specify a single State agency, established or designated, to administer or supervise the administration of the plan (42 CFR Sec.431.10(b)). Generally, the administering agency has been the State health agency, welfare agency, or an umbrella agency. A possible effect of the administering agency being the health department is that the welfare department has control over the intake of eligibles in the AFDC and SSI/SSP programs, individuals who automatically become eligible for Medicaid. This separation could create a span of control problem for the Medicaid agencies. Five States have designated the health department, 21 States have designated

Table 6.1.1

MEDICAID ELIGIBILITY DETERMINATION, PROGRAM OPERATION AND ADMINISTERING AGENCY

	ELIGIBILITY DETERMINATION			PROGRAM ADMINISTRATION		ADMINISTERING AGENCY			
STATE	1634	State Determination	209(B) State	State Administered	Locally Administered	Health Dept	Welfare Dept	Umbrella Agency	Other
ALABAMA	X	-	-	X	-	-	-	-	X
ALASKA	-	X	-	X	-	-	-	X	-
ARKANSAS	X	-	-	X	-	-	-	X	-
CALIFORNIA	X	-	-	-	X	X	-	-	-
COLORADO	X	-	-	X	-	-	X	-	-
CONNECTICUT	-	-	X	X	-	-	X	-	-
DELAWARE	X	-	-	X	-	-	-	X	-
DIST COLUMBIA	X	-	-	X	-	-	-	X	-
FLORIDA	X	-	-	X	-	-	-	X	-
GEORGIA	X	-	-	X	-	-	-	-	X
HAWAII	-	-	X	X	-	-	X	-	-
IDAHO	-	X	-	X	-	-	-	X	-
ILLINOIS	-	-	X	X	-	-	X	-	-
INDIANA	-	-	X	X	-	-	X	-	-
IOWA	X	-	-	X	-	-	X	-	-
KANSAS	-	X	-	X	-	-	-	X	-
KENTUCKY	X	-	-	X	-	-	X	-	-
LOUISIANA	X	-	-	X	-	-	-	X	-
MAINE	X	-	-	X	-	-	-	X	-
MARYLAND	X	-	-	X	-	X	-	-	-
MASSACHUSETTS	X	-	-	X	-	-	X	-	-
MICHIGAN	X	-	-	X	-	-	X	-	-
MINNESOTA	-	-	X	-	X	-	X	-	-
MISSISSIPPI	-	X	-	X	-	-	-	-	X
MISSOURI	-	-	X	X	-	-	X	-	-
MONTANA	X	-	-	X	-	-	-	X	-
NEBRASKA	-	-	X	-	X	-	X	-	-
NEVADA	-	X	-	X	-	-	-	X	-
NEW HAMPSHIRE	-	-	X	X	-	-	-	X	-
NEW JERSEY	X	-	-	X	-	-	X	-	-
NEW MEXICO	X	-	-	X	-	-	-	X	-
NEW YORK	X	-	-	-	X	-	X	-	-
N CAROLINA	-	-	X	-	X	-	-	X	-
N DAKOTA	-	-	X	-	X	-	X	-	-
OHIO	-	-	X	-	X	-	X	-	-
OKLAHOMA	-	-	X	X	-	-	-	X	-
OREGON	-	X	-	X	-	-	-	X	-
PENNSYLVANIA	X	-	-	X	-	-	X	-	-
RHODE ISLAND	X	-	-	X	-	-	-	X	-
S CAROLINA	X	-	-	-	X	-	X	-	-
S DAKOTA	X	-	-	X	-	-	X	-	-
TENNESSEE	X	-	-	X	-	X	-	-	-
TEXAS	X	-	-	X	-	-	X	-	-
UTAH	-	-	X	X	-	X	-	-	-
VERMONT	X	-	-	X	-	-	-	X	-
VIRGINIA	-	-	X	X	-	X	-	-	-
WASHINGTON	X	-	-	X	-	-	-	X	-
W VIRGINIA	X	-	-	X	-	-	X	-	-
WISCONSIN	X	-	-	X	-	-	-	X	-
WYOMING	X	-	-	X	-	-	-	X	-
TOTAL	30	6	14	42	8	5	21	21	3
% TOTAL U.S. $ FOR CATEGORY	75.5	2.9	21.6	57.7	42.3	16.7	62.3	17.0	3.9

the welfare department, 21 States have designated an umbrella agency, and three States have designated other agencies to administer the Medicaid program. The "other" agencies included the Office of the Governor in Alabama and an independent agency/ commission in Georgia and Mississippi.

6.1.2 Medicaid Management Information Systems

The Social Security Amendments of 1972 authorized 90 percent Federal matching to States for the costs of design, development, and installation or improvement of mechanized claims processing and information retrieval systems, and 75 percent for the costs of operating such systems, if the system is approved by the Administrator.

The MMIS is a general systems design that can be tailored by State Medicaid agencies to their own particular needs so long as the system meets Federally required minimum performance standards. The conceptual design includes six subsystems: recipient, provider, claims processing, reference file, surveillance and utilization review, and management and administration reporting. The first four subsystems work together with the overall objective of processing and paying each eligible provider for every valid claim. The other two subsystems consolidate and organize data necessary for managing and controlling the Medicaid program.

Table 6.1.2 summarizes current State progress in developing and implementing MMIS-type systems. Forty-one States have certified MMISs and operate a mechanized claims processing and information retrieval system. Two States, Connecticut and the District of Columbia, anticipate certification in FY 83. Two States, Maryland and Massachusetts, have implementation planned. Five States (Alaska, Delaware, Nevada, Rhode Island, and Wyoming) do not have and are not planning an MMIS. The five States have relatively few Medicaid recipients and claims and represent only 1.3 percent of all Medicaid expenditures. Thirty-three States reported that they had an active surveillance and utilization review (SUR) module while eleven States failed to respond for that data element. The number of integrity reviews for the most recent year reported by States varied from zero in Oregon and South Dakota to 3,522 in Illinois. Indiana, Ohio and Washington each reported over 1,000 integrity reviews.

Table 6.1.2

STATUS OF MEDICAID MANAGEMENT INFORMATION SYSTEM
MARCH 31, 1983

	Certification			MMIS Not Required	Active SUR Module	Number of Integrity Reviews
	Certified	Anticipated Implementation FY83	Planned			
ALABAMA	X	-	-	-	X	65
ALASKA	-	-	-	X	-	NA
ARKANSAS	X	-	-	-	X	770
CALIFORNIA	X	-	-	-	X	194
COLORADO	X	-	-	-	X	12
CONNECTICUT	-	X	-	-	NA	NA
DELAWARE	-	-	-	X	NA	NA
DIST COLUMBIA	-	X	-	-	NA	NA
FLORIDA	X	-	-	-	X	315
GEORGIA	X	-	-	-	X	120
HAWAII	X	-	-	-	NA	NA
IDAHO	X	-	-	-	NA	NA
ILLINOIS	X	-	-	-	X	3,522
INDIANA	X	-	-	-	X	2,204
IOWA	X	-	-	-	X	174
KANSAS	X	-	-	-	NA	NA
KENTUCKY	X	-	-	-	X	355
LOUISIANA	X	-	-	-	NA	NA
MAINE	X	-	-	-	X	176
MARYLAND	-	-	X	-	-	NA
MASSACHUSETTS	-	-	X	-	-	NA
MICHIGAN	X	-	-	-	X	589
MINNESOTA	X	-	-	-	NA	NA
MISSISSIPPI	X	-	-	-	X	352
MISSOURI	X	-	-	-	X	416
MONTANA	X	-	-	-	NA	NA
NEBRASKA	X	-	-	-	X	241
NEVADA	-	-	-	X	-	67
NEW HAMPSHIRE	X	-	-	-	-	405
NEW JERSEY	X	-	-	-	X	255
NEW MEXICO	X	-	-	-	X	103
NEW YORK	X	-	-	-	X	468
N CAROLINA	X	-	-	-	X	224
N DAKOTA	X	-	-	-	X	NA
OHIO	X	-	-	-	X	1,100
OKLAHOMA	X	-	-	-	X	232
OREGON	X	-	-	-	X	3
PENNSYLVANIA	X	-	-	-	X	152
RHODE ISLAND	-	-	-	X	-	NA
S CAROLINA	X	-	-	-	X	155
S DAKOTA	X	-	-	-	X	0
TENNESSEE	X	-	-	-	NA	NA
TEXAS	X	-	-	-	X	960
UTAH	X	-	-	-	X	2
VERMONT	X	-	-	-	X	90
VIRGINIA	X	-	-	-	X	289
WASHINGTON	X	-	-	-	X	1,392
W VIRGINIA	X	-	-	-	X	252
WISCONSIN	X	-	-	-	X	307
WYOMING	-	-	-	X	NA	NA
TOTAL STATES	41	2	2	5	33	

KEY: NA = Not Available

6.1.3 Medicaid Claims Processing Activity

States handle the processing of Medicaid claims in different ways. There is variability in who handles the claims for each service type. Table 6.1.3 displays five services and the processor for claims by State. For inpatient hospital services, 26 States use fiscal agents to handle claims; 20 States do their own claims processing; three States assign certain functions to fiscal agents and the States themselves perform certain functions; and one State, Texas, has a health insuring agency. Claims processing activities for physician services are provided in exactly the same manner as inpatient hospital services in each State. Claims processing activities for dental services are handled by fiscal agents in 27 States, by the States themselves in 19 States, and by a combination of fiscal agent/State in four States. Claims processing activities for prescription drugs are handled by fiscal agents in 27 States, by States themselves in 20 States, and by a combination of fiscal agent/State in three States. Claims processing activities for long-term care facilities are handled by fiscal agents in 24 States, by States themselves in 23 States, and by a combination of fiscal agent/State in three States.

6.1.4 Medicaid Quality Control

Each State agency must operate a Medicaid Quality Control (MQC) system designed to reduce erroneous expenditures by monitoring eligibility determinations, third-party liability activities, and claims processing (42 CFR Sec.431.800(a)). A summary report on eligibility findings and payment error findings for all cases in the six-month sample is submitted to HCFA. Table 6.1.4 contains data for the October - March, 1981 sampling period (the most recent period available). The payment error rate for each State means the rate of eligibility payment errors detected under the MQC system for that review period. This unduplicated total payment error rate ranged from 0.9 percent in Minnesota and Texas to 30.7 percent in the District of Columbia. Case error rate means the rate of eligibility case errors detected under the MQC system for the review period. Table 6.1.4 displays the total case error rate for each State as well as the case error rate by ineligibles, claims processing and third-party liability. The total case error rate ranges from

Table 6.1.3

MEDICAID CLAIMS PROCESSING ACTIVITY
MARCH 31, 1983

STATE	Inpatient Hospital	Physicians' Services	Dental Services	Prescription Drugs	Long Term Care Facilities
ALABAMA	F	F	F	F	F
ALASKA	F	F	F	F	F
ARKANSAS	F	F	F	F	S
CALIFORNIA	F	F	FS	F	F
COLORADO	F	F	F	F	F
CONNECTICUT	F	F	F	F	F
DELAWARE	F	F	F	F	F
DIST COLUMBIA	F	F	F	F	F
FLORIDA	F	F	F	F	F
GEORGIA	S	S	S	S	S
HAWAII	F	F	F	F	F
IDAHO	FS	FS	FS	FS	FS
ILLINOIS	S	S	S	S	S
INDIANA	F	F	F	F	F
IOWA	F	F	F	F	F
KANSAS	F	F	F	F	F
KENTUCKY	S	S	S	S	S
LOUISIANA	F	F	F	F	F
MAINE	S	S	S	S	S
MARYLAND	S	S	S	S	S
MASSACHUSETTS	S	S	F	F	S
MICHIGAN	S	S	S	S	S
MINNESOTA	S	S	S	S	S
MISSISSIPPI	F	F	F	F	F
MISSOURI	F	F	F	F	F
MONTANA	F	F	F	F	F
NEBRASKA	S	S	S	S	S
NEVADA	FS	FS	FS	FS	FS
NEW HAMPSHIRE	S	S	S	S	S
NEW JERSEY	F	F	F	F	S
NEW MEXICO	F	F	F	F	F
NEW YORK	F	F	F	F	F
N CAROLINA	F	F	F	F	F
N DAKOTA	S	S	S	S	S
OHIO	S	S	S	S	S
OKLAHOMA	S	S	S	S	S
OREGON	S	S	S	S	S
PENNSYLVANIA	S	S	S	S	S
RHODE ISLAND	S	S	S	S	S
S CAROLINA	S	S	S	S	S
S DAKOTA	S	S	S	S	S
TENNESSEE	F	F	F	F	F
TEXAS	I	I	S	S	S
UTAH	S	S	S	S	S
VERMONT	F	F	F	F	F
VIRGINIA	F	F	F	F	F
WASHINGTON	FS	FS	FS	FS	FS
W VIRGINIA	F	F	F	F	F
WISCONSIN	F	F	F	F	F
WYOMING	S	S	F	S	S

KEY: F = Fiscal Agent Processes Claims; S = State; FS = State and Fiscal Agent; I = Insurance.

Table 6.1.4

MEDICAID QUALITY CONTROL: PAYMENT AND CASE ERROR RATES
OCTOBER - MARCH, 1981

STATE	PAYMENT ERROR RATE	CASE ERROR RATE			
	Unduplicated Total	Total Case Error Rate	Ineligibles	Claims Processing	Third Party Liability
ALABAMA	1.1	3.9	2.0	1.5	0.3
ALASKA	13.3	21.9	13.9	7.5	0.5
ARKANSAS	1.6	5.9	2.7	2.6	0.5
CALIFORNIA	**	**	5.7	**	0.5
COLORADO	6.2	24.8	8.2	14.3	2.1
CONNECTICUT	7.7	20.8	14.1	3.6	2.8
DELAWARE	24.0	7.9	4.7	1.0	1.9
DIST COLUMBIA	30.7	32.2	7.3	24.5	0.3
FLORIDA	3.4	7.3	1.5	5.6	0.1
GEORGIA	3.6	6.0	2.9	2.8	0.3
HAWAII	**	**	4.4	**	1.7
IDAHO	11.8	12.8	11.5	0.6	0.7
ILLINOIS	6.1	10.1	8.6	0.7	0.7
INDIANA ****	2.1	10.7	5.0	4.5	0.7
IOWA	4.0	16.4	4.0	11.8	0.5
KANSAS	3.7	9.7	5.6	1.9	1.0
KENTUCKY	3.4	7.5	2.8	3.2	1.4
LOUISIANA	**	**	1.9	**	*
MAINE	7.7	13.2	8.1	2.8	1.7
MARYLAND ***	3.0	10.9	6.8	1.2	2.0
MASSACHUSETTS	8.5	14.1	6.9	3.9	3.1
MICHIGAN ****	5.8	15.8	4.9	4.4	5.9
MINNESOTA	0.9	8.0	4.0	1.8	1.6
MISSISSIPPI	4.9	7.4	6.4	0.1	0.8
MISSOURI	1.0	4.9	3.2	0.0	1.5
MONTANA	**	**	9.4	**	1.0
NEBRASKA	5.6	18.1	3.2	13.1	1.5
NEVADA	**	**	0.8	**	0.5
NEW HAMPSHIRE	10.2	11.6	5.7	2.9	3.0
NEW JERSEY	3.5	6.9	4.9	0.9	1.0
NEW MEXICO	1.8	10.9	6.2	3.4	1.1
NEW YORK ****	3.1	12.2	9.0	3.1	0.0
N CAROLINA	6.5	14.3	6.8	4.2	2.5
N DAKOTA	7.0	17.7	10.8	4.9	1.3
OHIO	2.7	10.9	7.8	0.3	2.7
OKLAHOMA	3.7	6.9	4.1	1.8	0.1
OREGON	4.7	16.1	6.1	7.6	2.4
PENNSYLVANIA	**	**	7.4	**	0.1
RHODE ISLAND	3.0	5.2	4.2	0.3	0.4
S CAROLINA	**	**	1.5	**	0.3
S DAKOTA	**	**	3.2	**	0.1
TENNESSEE	2.3	5.2	2.1	2.4	0.5
TEXAS	0.9	2.6	2.1	0.0	0.4
UTAH	7.0	22.5	5.5	14.4	1.0
VERMONT	2.5	6.8	3.5	0.7	2.1
VIRGINIA	3.8	7.0	5.0	0.8	1.2
WASHINGTON	3.5	16.1	5.5	9.6	1.0
W VIRGINIA	8.1	7.1	5.4	1.4	0.2
WISCONSIN ****	**	**	8.2	**	0.2
WYOMING	**	**	6.5	**	0.6

* Rate is greater than 0.0 but less than .05 percent.
** Not available due to implementation of revised sampling methodology.
*** Rate based on small substratum sample size and may be less than reliable.
**** Tentative Rates.
SOURCE: Bureau of Quality Control, HCFA.

2.6 percent in Texas to 32.2 percent in the District of Columbia. Case error rates for ineligibles range up to 14.1 percent, for claims processing up to 24.5 percent, and for third-party liability up to 5.9 percent.

6.1.5 State Administration and Training

Medicaid regulations establish certain standards concerning personnel administration and training in State Medicaid programs (42 CFR Sec.432.30-66). The State plan must provide for a training program for agency personnel and this program must include inservice training for new staff, be related to job duties, and be consistent with program objectives. Finally, the State plan must provide for the training and effective use of sub-professional staff and unpaid volunteers. Federal financial participation is available to States for administrative costs. Table 6.1.5 displays the amount computable for Federal funding, the adjusted Federal share, and the State share for FY 81 by State. Data for FY 82 were not available at the time of this writing.

6.1.6 Waiver of Medicaid Requirements

A State Medicaid plan must provide that certain requirements regarding Statewideness be met (42 CFR Sec.431.50(b)). Statewideness means that the State plan will be in operation through a system of local offices, under equitable standards for assistance and administration that are mandatory throughout the State. If the State plan is administered by political subdivisions of the State, it is mandatory on those subdivisions. The Medicaid agency must assure that the plan is continuously in operation in all local offices or agencies through methods for informing staff, systematic planned examination and evaluation of operations in local offices, reports, controls, and other methods. However, there are exceptions with respect to:

- Services offered by comprehensive health services organizations;
- Services offered by rural health clinics;
- Arrangements to purchase medical devices or laboratory and x-ray services;
- Lock-in or lock-out restrictions; and

Table 6.1.5

MEDICAID COSTS FOR STATE ADMINISTRATION AND TRAINING
FISCAL YEAR 1981

STATE	Amount Computable For Federal Funding	Adjusted Federal Share	State Share
ALABAMA	$10,129,000	$7,074,546	$3,054,454
ALASKA	$2,114,000	$1,159,821	$954,179
ARKANSAS	$8,965,000	$5,357,124	$3,607,876
CALIFORNIA	$190,501,000	$127,797,573	$62,703,427
COLORADO	$8,474,000	$6,438,232	$2,035,768
CONNECTICUT	$16,891,000	$9,307,176	$7,583,824
DELAWARE	$2,374,000	$1,423,500	$950,500
DIST COLUMBIA	$9,136,000	$7,237,680	$1,898,320
FLORIDA	$27,779,000	$18,384,156	$9,394,844
GEORGIA	$23,457,000	$15,893,273	$7,563,727
HAWAII	$5,155,000	$3,314,168	$1,840,832
IDAHO	$3,479,000	$2,224,595	$1,254,405
ILLINOIS	$55,021,000	$32,638,717	$22,382,283
INDIANA	$18,292,000	$10,876,781	$7,415,219
IOWA	$9,662,000	$5,498,461	$4,163,539
KANSAS	$8,159,000	$4,731,472	$3,427,528
KENTUCKY	$17,385,000	$10,096,023	$7,288,977
LOUISIANA	$18,103,000	$9,838,240	$8,264,760
MAINE	$6,988,000	$4,568,332	$2,419,668
MARYLAND	$19,973,000	$11,122,190	$8,850,810
MASSACHUSETTS	$28,520,000	$15,419,499	$13,100,501
MICHIGAN	$59,778,000	$35,610,500	$24,167,500
MINNESOTA	$25,085,000	$13,359,274	$11,725,726
MISSISSIPPI	$11,283,000	$8,372,417	$2,910,583
MISSOURI	$14,101,000	$8,365,903	$5,735,097
MONTANA	$4,443,000	$2,718,971	$1,724,029
NEBRASKA	$7,954,000	$4,774,256	$3,179,744
NEVADA	$4,261,000	$2,279,033	$1,981,967
NEW HAMPSHIRE	$4,463,000	$2,779,900	$1,683,100
NEW JERSEY	$32,641,000	$27,530,843	$5,110,157
NEW MEXICO	$5,959,000	$3,679,228	$2,279,772
NEW YORK	$257,762,000	$152,087,987	$105,674,013
N CAROLINA	$27,794,000	$17,154,079	$10,639,921
N DAKOTA	$4,411,000	$2,577,413	$1,833,587
OHIO	$42,826,000	$23,063,902	$19,762,098
OKLAHOMA	$27,551,000	$16,625,685	$10,925,315
OREGON	$19,838,000	$11,854,930	$7,983,070
PENNSYLVANIA	$67,980,000	$38,028,223	$29,951,777
RHODE ISLAND	$6,354,000	$3,866,786	$2,487,214
S CAROLINA	$10,863,000	$6,254,996	$4,608,004
S DAKOTA	$2,798,000	$1,829,450	$968,550
TENNESSEE	$16,317,000	$12,929,262	$3,387,738
TEXAS	$88,129,000	$55,148,862	$32,980,138
UTAH	$6,103,000	$4,512,656	$1,590,344
VERMONT	$4,728,000	$3,363,405	$1,364,595
VIRGINIA	$17,503,000	$10,889,355	$6,613,645
WASHINGTON	$22,495,000	$16,282,023	$6,212,977
W VIRGINIA	$8,860,000	$5,018,402	$3,841,598
WISCONSIN	$28,866,000	$21,892,192	$6,973,808
WYOMING	$860,000	$457,915	$402,085
TOTAL STATES	$1,322,563,000	$823,709,407	$498,853,593

SOURCE: HCFA-64 Quarterly Report, Bureau on Program Operations, HCFA.

- Services offered under a waiver with respect to home and community based services.

In addition, the Secretary may waive the requirements of sections 1902 and 1903(m) of the Act to the extent he or she finds proposed improvements in the provision of services under Medicaid to be cost-effective, efficient, and consistent with the objectives of the Medicaid program. Such waivers are allowed for:

- Case-management systems;
- Locality as central broker;
- Sharing of cost savings; and
- Restrictions of freedom of choice.

Waiver activities are discussed below for section 2175 freedom of choice waivers, and section 2176 home and community based services waivers (PL 97-35). Note that the waiver activities are reported as of April 1, 1983.[1/]

Section 2175 Freedom of Choice Waivers. Section 2175 attempts to increase the importance of price considerations in the decision about when, where, and how to utilize health care services. Each of the waivers focuses on a different part of the health care decision making process and allows a State to:

- Implement a primary care case management system focusing on primary care physicians;
- Allow a locality to act as central broker in assisting Medicaid recipients in selecting among competing health plans;
- Share with recipients, through the provision of additional services, savings resulting from recipients' use of more cost-effective medical care; and

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1/ For current information on the status of section 2175 freedom of choice waivers and section 2176 home and community based services waivers contact the Division of Provider Services Coverage Policy, BERC, HCFA.

- Restrict recipients to receiving services (other than in emergency situations) from only efficient and cost effective providers.

The waivers can be granted for a period of up to two years and a State may request a continuation. There is no limit to the number of waivers a State may submit.

As of March 31, 1983, 35 freedom of choice waivers had been received by HCFA central office from a total of 17 States. The States submitting these waivers as well as their current status are identified in Table 6.1.6(A). Nineteen (54%) of the waiver applications submitted had been approved as of March 31, 1983. The waiver applications are classified based upon either a reference to a specific provision within the application itself or HCFA's preliminary classification of the request when received. Of the 35 waiver applications received, 22 were submitted under the primary care case management authority, none were submitted under localities as brokers, six were submitted under cost-sharing with recipients, four were submitted under restriction to cost-effective providers, and three were submitted that were unspecified. Of the 19 waiver applications which have been fully approved, 16 were submitted under primary care case management systems, two were submitted under cost-effective providers, and one was submitted under cost-sharing with recipients. Of the pending waiver applications, two were submitted under primary care case management, one under cost-sharing with recipients and one under restriction to cost-effective providers.

Section 2176 Home and Community Based Services Waivers. Section 1915(c) of the Omnibus Reconciliation Act permits States to offer, under a waiver, an array of home and community based services that an individual needs to avoid institutionalization. As of March 31, 1983, 53 home and community based services waiver applications had been received by HCFA central office from a total of 38 States. The States submitting these waivers as well as their current status are identified in Table 6.1.6(B). Date of approval is given for those applications that have been approved. The waiver applications are classified as to type of service provided by eligibility group. There are eight possible service categories and three identifiable eligibility groups (aged/disabled, mentally retarded, mentally ill).

Table 6.1.6(A)

2175 FREEDOM OF CHOICE WAIVER APPLICATIONS*

STATE	Number Of Applications	Primary Care Case Management	Localities As Brokers	Cost Sharing With Recipients	Restriction to Cost Effective Providers	Unspecified
ALABAMA	0	-	-	-	-	-
ALASKA	0	-	-	-	-	-
ARKANSAS	0	-	-	-	-	-
CALIFORNIA	2	A -	- -	- -	- A	- -
COLORADO	2	A A	- -	- -	- -	- -
CONNECTICUT	1	-	-	D	-	-
DELAWARE	0	-	-	-	-	-
DIST COLUMBIA	0	-	-	-	-	-
FLORIDA	0	-	-	-	-	-
GEORGIA	0	-	-	-	-	-
HAWAII	1	A	-	-	-	-
IDAHO	0	-	-	-	-	-
ILLINOIS	0	-	-	-	-	-
INDIANA	0	-	-	-	-	-
IOWA	0	-	-	-	-	-
KANSAS	0	-	-	-	-	-
KENTUCKY	1	A	-	-	-	-
LOUISIANA	0	-	-	-	-	-
MAINE	1	-	-	-	-	D
MARYLAND	0	-	-	-	-	-
MASSACHUSETTS	2	W W	- -	- -	- -	- -
MICHIGAN	3	A A A	- - -	- - -	- - -	- - -

Table 6.1.6(A) (Con't)

2175 FREEDOM OF CHOICE WAIVER APPLICATIONS*

STATE	Number Of Applications	Primary Care Case Management	Localities As Brokers	Cost Sharing With Recipients	Restriction to Cost Effective Providers	Unspecified
MINNESOTA	0	-	-	-	-	-
MISSISSIPPI	1	-	-	-	-	D
MISSOURI	0	-	-	-	-	-
MONTANA	0	-	-	-	-	-
NEBRASKA	0	-	-	-	-	-
NEVADA	0	-	-	-	-	-
NEW HAMPSHIRE	2	A -	- -	- D	- -	- -
NEW JERSEY	1	-	-	-	-	D
NEW MEXICO	0	-	-	-	-	-
NEW YORK	2	A -	- -	- -	- P	- -
N CAROLINA	1	A	-	-	-	-
N DAKOTA	0	-	-	-	-	-
OHIO	0	-	-	-	-	-
OKLAHOMA	0	-	-	-	-	-
OREGON	0	-	-	-	-	-
PENNSYLVANIA	2	A P	- -	- -	- -	- -
RHODE ISLAND	0	-	-	-	-	-
S CAROLINA	0	-	-	-	-	-
S DAKOTA	0	-	-	-	-	-
TENNESSEE	0	-	-	-	-	-
TEXAS	0	-	-	-	-	-
UTAH	1	A	-	-	-	-

Table 6.1.6(A) (Con't)

2175 FREEDOM OF CHOICE WAIVER APPLICATIONS*

STATE	Number Of Applications	Primary Care Case Management	Localities As Brokers	Cost Sharing With Recipients	Restriction to Cost Effective Providers	Unspecified
VERMONT	0	-	-	-	-	-
VIRGINIA	0	-	-	-	-	-
WASHINGTON	3	D	-	-	-	-
		D	-	-	-	-
		-	-	-	A	-
W VIRGINIA	0	-	-	-	-	-
WISCONSIN	9	A	-	-	-	-
		A	-	-	-	-
		-	-	W	-	-
		-	-	D	-	-
		-	-	W/D/A	-	-
		-	-	-	D	-
		A	-	-	-	-
		P	-	-	-	-
		-	-	P	-	-
WYOMING	0	-	-	-	-	-

* A=Approved by HCFA D=Denied by HCFA P=Pending decision by HCFA W=Withdrawn by State
Data as of March 31, 1983.

Table 6.1.6(D)

SECTION 2176 WAIVER REQUESTS FOR
HOME AND COMMUNITY BASED SERVICES

STATE	Number Of Waiver Requests	Waiver Status*	Date Of Approval	SERVICES PROVIDED AS ALTERNATIVE TO INSTITUTIONAL CARE BY ELIGIBILITY GROUP**							
				Case Management	Homemaker	Home Health Aide	Personal Care Service	Adult Day Care	Habilitation	Respite Care	Other
ALABAMA	1	A	03-03-83	--	--	--	--	--	MR	--	--
ALASKA	1	R		--	A/D	A/D	A/D	A/D	A/D	A/D	A/D
ARKANSAS	0										
CALIFORNIA	4	D		A/D	A/D	--	A/D	--	--	--	--
		D		--	MR	MR	--	MR	MR	MR	MR
		A	11-01-82	--	MR	MR	--	MR	MR	MR	MR
		A	12-10-82	MI	MI	MI	MI	--	--	MI	MI
COLORADO	2	A		A/D	A/D	--	--	A/D	--	A/D	A/D
		A		MR	--	--	MR,MI	--	MR	MR,MI	MR,MI
CONNECTICUT	1	R		A/D	A/D	--	A/D	A/D	--	A/D	A/D
DELAWARE	0										
DIST COLUMBIA	0										
FLORIDA	2	A	04-21-82	A/D	A/D	--	A/D	A/D	--	A/D	A/D
		A	04-21-82	MR	--	--	--	MR	--	MR	MR
GEORGIA	1	A	06-07-82	--	--	A/D,MR	A/D,MR	--	--	--	A/D,MR
HAWAII	1	R		MR	MR	MR	MR	MR	MR	MR	MR
IDAHO	0										
ILLINOIS	2	A	06-20-83	A/D	A/D	--	A/D	A/D	--	--	A/D
		R		MR	--	--	--	MR	MR	MR	MR
INDIANA	0										
IOWA	1	A	05-07-82	A/D,MR	--	--	--	--	--	--	--
KANSAS	3	A	03-18-82	A/D,MR	A/D,MR	A/D,MR	A/D,MR	A/D,MR	A/D,MR	A/D,MR	A/D,MR
		R		--	--	--	--	--	--	--	A/D,MR
		D		--	--	--	--	--	--	--	--
KENTUCKY	2	A	09-22-82	MR	MR	MR	MR	MR	MR	MR	--
		A	09-22-82	A/D	A/D	A/D	A/D	A/D	A/D	A/D	A/D
LOUISIANA	1	A	01-06-82	A/D,MR	--	--	--	A/D,MR	A/D,MR	--	--
MAINE	0										
MARYLAND	1	A	03-16-83	MR	--	--	--	MR	MR	--	--

Table 6.1.6(B) (Con't)

SECTION 2176 WAIVER REQUESTS FOR
HOME AND COMMUNITY BASED SERVICES

STATE	Number Of Waiver Requests	Waiver Status*	Date Of Approval	SERVICES PROVIDED AS ALTERNATIVE TO INSTITUTIONAL CARE BY ELIGIBILITY GROUP**							
				Case Management	Homemaker	Home Health Aide	Personal Care Service	Adult Day Care	Habilitation	Respite Care	Other
MASSACHUSETTS	2	A R	01-01-83	-- --	-- --	-- --	-- --	-- --	-- --	A/D --	A/D AGED/BLIND
MICHIGAN	1	R		--	--	--	--	--	--	--	D
MINNESOTA	1	A	07-23-82	A/D	A/D	A/D	A/D	A/D	--	A/D	A/D
MISSISSIPPI	0										
MISSOURI	1	A	04-22-82	--	A/D	--	--	A/D	--	A/D	A/D
MONTANA	1	A	02-02-82	MR	MR	--	--	MR	MR	MR	MR
NEBRASKA	1	R		MR,MI	MI	--	MI	--	MR,MI	--	MR,MI
NEVADA	2	A W	03-31-83	MR D	-- D	-- --	-- D	-- --	MR --	-- D	-- --
NEW HAMPSHIRE	0										
NEW JERSEY	2	A R		MR A/D	-- A/D	-- A/D	-- --	-- A/D	MR --	MR A/D	-- A/D
NEW MEXICO	0										
NEW YORK	1	A	12-02-82	A/D	--	--	--	--	--	A/D	A/D
N CAROLINA	3	A A R	10-01-82 02-22-83	A/D MR --	A/D MR --	A/D MR --	-- -- --	A/D MR --	-- MR --	A/D MR --	A/D MR --
N OAKOTA	1	R		MR	MR	MR	MR	MR	MR	MR	--
OHIO	0										
OKLAHOMA	0										
OREGON	1	A	12-23-81	MR	A/D,MR	--	MI	--	MR	MR	A/D,MR
PENNSYLVANIA	1	R		MR	--	--	--	MR	MR	--	MR
RHODE ISLAND	1	A	06-30-82	A/D	A/D	--	--	A/D	--	--	A/D
S CAROLINA	1	A	08-20-82	A/D	--	--	--	--	--	--	--
S OAKOTA	1	A	07-06-82	MR	--	--	--	--	MR	--	MR

Table 6.1.6(B) (Con't)

SECTION 2176 WAIVER REQUESTS FOR
HOME AND COMMUNITY BASED SERVICES

STATE	Number Of Waiver Requests	Waiver Status*	Date Of Approval	SERVICES PROVIDED AS ALTERNATIVE TO INSTITUTIONAL CARE BY ELIGIBILITY GROUP**							
				Case Management	Homemaker	Home Health Aide	Personal Care Service	Adult Day Care	Habilitation	Respite Care	Other
TENNESSEE	1	R		--	--	A/D	--	--	--	--	--
TEXAS	1	R		A/D	--	--	A/D	--	--	--	A/D
UTAH	1	R		A/D,MR	A/D,MR	A/D,MR	A/D,MR	A/D,MR	MR	A/D,MR	A/D,MR
VERMONT	1	A	06-23-82	--	MR,MI	--	--	MR,MI	MR,MI	MR,MI	MR,MI
VIRGINIA	1	A	06-18-82	--	--	--	A/D	--	--	--	--
WASHINGTON	2	A R	01-01-83	A/D MR	-- --	-- --	A/D --	-- --	-- MR	-- MR	A/D MR
W VIRGINIA	1	A		A/D	A/D	A/D	--	--	MR	A/D,MR	A/D
WISCONSIN	1	R		MR	--	--	--	--	MR	MR	--
WYOMING	0										

* A = Approved by HCFA O = Denied by HCFA R = Received by HCFA W = Withdrawn by State. Data as of March 31, 1983.

** A = Aged O = Disabled MR = Mentally Retarded MI = Mentally Ill

Of the 53 waiver applications, 32 had been approved and three disapproved by HCFA as of March 31, 1983. The approved applications have provisions to provide services for the aged and disabled population in 19 States, the mentally retarded in 18 States, and the mentally ill in three States.

There are eight service categories that can be provided as home and community based services. Each approved waiver provides on the average three and one-half services. Of the approved applications, 25 waivers provide for case management services, 17 provide homemaker, 10 provide home health aide services, 12 provide personal care services, 17 provide adult day care services, 16 provide habilitation services, 20 provide respite care, and 23 provide "other" services. "Other" services are delineated on Table 6.1.6(C) and include such services as transportation, minor home modifications, meals on wheels, hospice, counseling, chore, etc.

6.2 FINANCE

Payments to providers of health care to the Medicaid eligible population come from several sources including:

- The Federal government through the Medicaid Federal Medical Assistance Percentages formula;
- The Federal government through the Medicare program;
- State governments;
- Local governments (in some States);
- Third parties who are otherwise liable for care provided to Medicaid eligibles; and
- The Medicaid eligibles themselves.

This section presents data on Federal, State, local and third-party collections. Information is not available on private third-party payments or expenditures contributed by the Medicaid eligibles themselves.

Table 6.1.6(C)

SECTION 2176 WAIVER REQUESTS FOR
HOME AND COMMUNITY BASED SERVICES

OTHER - ALTERNATIVES TO INSTITUTIONALIZATION

STATE	Number Of Waiver Requests	Waiver Status*	OTHER SERVICES PROVIDED AS ALTERNATIVES TO INSTITUTIONAL CARE BY ELIGIBILITY GROUP**	
ALABAMA	1	A	--	
ALASKA	1	R	A/D	Physical Modification to Home, Adult Residential Care, Adult Foster Care, Home Health Care
ARKANSAS	0			
CALIFORNIA	4	D	--	
		D	MR	Personal Support, Transportation & Regional Center Direct Client Support Services
		A	MR	Personal Support, Transportation & Regional Center Direct Client Support Services
		A	MI	Transportation
COLORADO	2	A	A/D	Meals on Wheels, Non-Med Transportation, Minor Home Mods, Elec Monitor/Communicate Devices
		A	MR,MI	Non-Medical Transportation
CONNECTICUT	1	R	A/D	OT, Companion, Chore, Day Care, Non-Med Transp, Meals on Wheels, Mental Health Counseling in Home
DELAWARE	0			
DIST COLUMBIA	0			
FLORIDA	2	A	A/D	Counseling, Escort, Health Supp & Placement Svcs, Diag & Eval, Family Placement, Training, Therapies, Transport
		A	MR	Counseling, Escort, Health Supp Scvs, Diag & Eval, Family Placement, Training, Therapies, & Transportation
GEORGIA	1	A	A/D,MR	Nurse, Special Med Supply Equip Appliance, PT, OT, ST, Therapeut Activity, MSS
HAWAII	1	R	MR	Physician Extenders
IDAHO	0			
ILLINOIS	2	A	A/D	Chore/Housekeeping,Emergency Response Services
		R	MR	Minor Home Adaptation
INDIANA	0			
IOWA	1	A	--	
KANSAS	3	A	A/D,MR	Hospice
		R	A/D,MR	PT, OT, ST to Individuals in Adult Care Homes in Five Counties
		D	--	Two Levels of ICF Care
KENTUCKY	2	A	--	
		A	A/D	Minor Home Adaptations
LOUISIANA	1	A	--	
MAINE	0			

Table 6.1.6(C) (Con't)
SECTION 2176 WAIVER REQUESTS FOR
HOME AND COMMUNITY BASED SERVICES

OTHER - ALTERNATIVES TO INSTITUTIONALIZATION

STATE	Number Of Waiver Requests	Waiver Status*	OTHER SERVICES PROVIDED AS ALTERNATIVES TO INSTITUTIONAL CARE BY ELIGIBILITY GROUP**	
MARYLAND	1	A	--	
MASSACHUSETTS	2	A	A/D	Personal Emergency Response system
		R	AGED/BLIND	Pers Emrg Resp, Hous Adapt, Orient & Mblty, Sign Lang Skls, Fmly Invlv Svcs, Comm Based Res Care
MICHIGAN	1	R	D	Home Care for Disabled Children
MINNESOTA	1	A	A/D	Foster Care for the Elderly
MISSISSIPPI	0			
MISSOURI	1	A	A/D	Chore, Adult Family Home Services
MONTANA	1	A	MR	Nursing, PT, OT, ST and Psychologists' Services
NEBRASKA	1	R	MR,MI	MI-Psychiatric Day Services MR-Transportation
NEVADA	2	A	--	
		W	--	
NEW HAMPSHIRE	0			
NEW JERSEY	2	A	--	
		R	A/D	Medical Day Care, Medical Transportation, Pharmaceutical
NEW MEXICO	0			
NEW YORK	1	A	A/D	MSS, RT Nutri Counsel, Congreg Meals, Soc Day Care & Transp, Moving Assist, Home Improve & Mainten
N CAROLINA	3	A	A/D	Screening, Chore Svcs, Prep & Delivery of Meals, DME & Home Mobility Aids
		A	MR	Screening, Chore Svcs, Prep & Delivery of Meals, DME & Home Mobility Aids
		R	--	
N DAKOTA	1	R	--	
OHIO	0			
OKLAHOMA	0			
OREGON	1	A	A/D,MR	Housekeeper/Chore, Non-Med Transp, Substitute Living Svcs, Minor Phys Adapts, Resident Care Facs
PENNSYLVANIA	1	R	MR	Transportation, Specialized Therapy, Minor Physical Adaptations
RHODE ISLAND	1	A	A/D	Devices to Adapt Home Environs, Minor Asst Devices, Transp, Other State Plan Services

Table 6.1 6(C) (Con't)

SECTION 2176 WAIVER REQUESTS FOR
HOME AND COMMUNITY BASED SERVICES

OTHER - ALTERNATIVES TO INSTITUTIONALIZATION

STATE	Number Of Waiver Requests	Waiver Status*	OTHER SERVICES PROVIDED AS ALTERNATIVES TO INSTITUTIONAL CARE BY ELIGIBILITY GROUP**	
S CAROLINA	1	A	--	
S DAKOTA	1	A	MR	Diet, Nurse, Psychol, Dental, Physician, Pharmacy, PT, OT, ST, Audio Optometric, Eyeglasses & Transp
TENNESSEE	1	R	--	
TEXAS	1	R	A/D	Emerg Response Systems, Home Delivered Meals, Minor Home Modifications, Rehabilitation Svcs
UTAH	1	R	A/D,MR	Hospice Services
VERMONT	1	A	MR,MI	Hospice Services
VIRGINIA	1	A	--	
WASHINGTON	2	A R	A/D MR	
W VIRGINIA	1	A	A/D	Chore, Adult Day Care, Adult Fam Care & Personal Care Home Support Svcs, Skilled Nursing Svcs
WISCONSIN	1	R	--	
WYOMING	0			

* A = Approved by HCFA D = Denied by HCFA R = Received by HCFA W = Withdrawn by State. Data as of March 31, 1983.

** A = Aged D = Disabled MR = Mentally Retarded MI = Mentally Ill

6.2.1 Medicaid Vendor Payments by State

Payments are made to States, on the basis of a Federal medical assistance percentage, for part of their expenditures for services under an approved State plan. The formula used in determining the State and Federal share (42 CFR Sec.433.10) is as follows:

State share = $(\text{State per capita income})^2 / (\text{National per capita income})^2 \times 45\%$

Federal share = 100% minus the State share (minimum of 50% and a maximum of 83%)

By design, the formula provides a higher percentage of Federal matching funds to States with low per capita incomes (up to a maximum of 83 percent); and a lower percentage of Federal matching funds to States with high per capita incomes (down to a minimum of 50 percent). The percent Federal share is computed biannually.

Table 6.2.1 presents the Federal Medicaid assistance percentages in effect for FY 82-83. No State receives the maximum Federal match (Mississippi receives the highest at 77.36 percent) while 13 States receive the minimum. These percentages apply to medical vendor payments only. Federal matching rates for other expenditures are as follow:

- Administration of family planning services - 90 percent;
- State Medicaid fraud control units - 90 percent;
- Design, development, or installation of MMIS - 90 percent;
- Operation of MMIS - 75 percent;
- Compensation and training of skilled professional medical personnel and staff directly supporting those personnel - 75 percent; and
- Contracted PSRO medical and utilization review - 75 percent.
- All other activities the Secretary finds necessary for proper and efficient administration of the State plan - 50 percent.

As of the first quarter of FY 1982, HCFA reduced total Federal payments to which a State is otherwise entitled under the Medicaid program by the following percentages (42 CFR 433.205):

Table 6.2.1

MEDICAID VENDOR PAYMENTS BY STATE
FISCAL YEAR 1981 1/
(In Thousands)

STATE	Total Payment Computable For Federal Funding	Percent Federal Share FY 82-3	Adjusted Federal Share	State Share
UNITED STATES	$28,354,432		$15,825,320	$12,529,093
ALABAMA	$291,655	71.13	$216,889	$74,766
ALASKA	$44,333	50.00	$22,378	$21,955
ARKANSAS	$281,206	72.16	$207,644	$73,562
CALIFORNIA	$3,733,516	50.00	$1,869,822	$1,863,694
COLORADO	$217,807	52.28	$121,479	$96,328
CONNECTICUT	$379,777	50.00	$190,405	$189,372
DELAWARE	$55,188	50.00	$28,312	$26,876
DIST COLUMBIA	$160,684	50.00	$78,568	$82,116
FLORIDA	$512,476	57.92	$296,383	$216,093
GEORGIA	$553,847	66.28	$365,162	$188,685
HAWAII	$111,116	50.00	$56,540	$54,576
IDAHO	$60,246	65.43	$41,531	$18,715
ILLINOIS	$1,481,947	50.00	$729,507	$752,440
INDIANA	$448,936	56.73	$253,634	$195,302
IOWA	$278,003	55.35	$154,437	$123,566
KANSAS	$222,828	52.50	$118,516	$104,312
KENTUCKY	$371,293	67.95	$254,093	$117,200
LOUISIANA	$420,534	66.85	$322,042	$98,492
MAINE	$162,280	70.63	$116,203	$46,077
MARYLAND	$480,728	50.00	$230,737	$249,991
MASSACHUSETTS	$1,159,932	53.56	$582,457	$577,456
MICHIGAN	$1,375,480	50.00	$685,061	$690,419
MINNESOTA	$679,653	54.39	$380,263	$299,390
MISSISSIPPI	$253,434	77.36	$198,533	$54,851
MISSOURI	$383,779	60.38	$259,474	$124,305
MONTANA	$87,741	65.34	$55,169	$32,572
NEBRASKA	$126,502	58.12	$76,561	$49,941
NEVADA	$62,187	50.00	$31,812	$30,375
NEW HAMPSHIRE	$84,494	59.41	$51,048	$33,446
NEW JERSEY	$846,861	50.00	$434,663	$412,198
NEW MEXICO	$91,905	67.19	$65,345	$26,560
NEW YORK	$5,072,503	50.88	$2,672,477	$2,400,026
N CAROLINA	$486,523	67.81	$331,039	$155,484
N DAKOTA	$60,551	62.11	$37,613	$22,938
OHIO	$1,054,083	55.10	$588,614	$465,469
OKLAHOMA	$361,737	59.91	$228,394	$133,343
OREGON	$198,602	52.81	$112,142	$86,460
PENNSYLVANIA	$1,492,896	56.78	$809,929	$682,967
RHODE ISLAND	$183,441	57.77	$108,456	$74,985
S CAROLINA	$300,889	70.77	$208,932	$91,957

Table 6.2.1 (Con't)

MEDICAID VENDOR PAYMENTS BY STATE
FISCAL YEAR 1981 1/
(In Thousands)

STATE	Total Payment Computable For Federal Funding	Percent Federal Share FY 82-3	Adjusted Federal Share	State Share
S DAKOTA	$72,212	68.19	$49,077	$23,135
TENNESSEE	$434,718	68.53	$303,664	$131,054
TEXAS	$1,200,298	55.75	$688,355	$511,943
UTAH	$92,607	68.64	$68,754	$23,853
VERMONT	$71,610	68.59	$53,694	$17,916
VIRGINIA	$440,988	56.74	$264,039	$176,949
WASHINGTON	$415,809	50.00	$216,571	$199,238
W VIRGINIA	$129,036	67.95	$86,323	$42,713
WISCONSIN	$848,625	58.02	$494,143	$354,482
WYOMING	$16,936	50.00	$8,386	$8,550

1/ Figures represent each State's claims for Medicaid Vendor Payments and include prior period claims, collections, deferrals, disallowances, and suspensions taken by the regional office or paid in that fiscal year. This data is taken from Federal finance records and may not represent State expenditure claims. Hence, States did not verify this particular figure.

SOURCE: HCFA-64 Quarterly Report, Bureau of Program Operations, HCFA.

- Three percent in FY 82;
- Four percent in FY 83;
- Four and one-half percent in FY 84;

However, HCFA will decrease the above specified reduction by one percentage point for a quarter for a State, for each of the following three conditions that the State meets.

- Hospital cost review program - operation by the State of a hospital cost review program that meets Federal criteria;
- Unemployment levels - an unemployment rate in the State, for the quarter before the quarter covered by the Federal payment, that is equal to or greater than 150 percent of the national unemployment rate for the same period; and
- Fraud and abuse and third party liability recoveries--for the quarter before the quarter covered by the Federal payment, recovery through fraud and abuse initiatives of an amount equal to one percent of the FFP for the quarter covered by the payment. For fiscal year 1982 only, this total may include recoveries from liable third parties.

The share of total expenditures for medical assistance borne by the States will also vary with the extent to which States provide medical assistance to State-only categories of eligibles, and offer services which do not qualify for Federal financial participation.

The first column of Table 6.2.1 presents the total Medicaid vendor payments subject to Federal financial participation (FFP). These figures represent each State's claim and include prior period claims, collections, deferrals, disallowances, and suspensions taken by the regional office or paid in that fiscal year. Thus, these figures are not exactly the same as the figures reported by States on their HCFA-2082 annual report. The total U.S. payment computable for Federal funding in 1981 was approximately $28 billion with New York ($5.1 billion) and Wyoming ($17 million) being the two extremes. The adjusted Federal share is the official accounting of payments to providers and reflects such accounting adjustments as changes in payments to cost reimbursed providers following year end audits. The adjusted Federal share for the U.S. in 1981 was $15.8 billion with New York receiving the largest amount ($2.7 billion) and Wyoming receiving the smallest amount ($8.4 million).

The total States' share of Medicaid vendor payments for FY 81 was $12.5 billion. Some States require that local jurisdictions pay part of the State share. However, a State must pay at least 40 percent of the non-Federal share of total expenditures under the plan (42 CFR Sec.433.33(b)). Local jurisdictions can pay up to 60 percent of the non-Federal share. Not all States require that local jurisdictions share in the cost and those that do are not required to report that amount to HCFA.

6.2.2 Local Funding Formulas for Medicaid Vendor Payments

Table 6.2.2 presents the local funding formulas for 13 States for Medicaid vendor payments. These formulas range from Colorado requiring the 20 largest counties to pay 2 percent of the State's share for all new ICF nursing home admissions to New Hampshire requiring counties to pay approximately 25 percent of the non-Federal share. Thus, there is a wide variance in the amount of local funds required by the States that use local funding.

6.2.3 Medicaid Third Party Collections

Table 6.2.3 reports the Medicaid Third Party Collections for FY 1981. The State agencies must take reasonable measures to determine the legal liability of third parties to pay for services under the plan. The agency has the following options for payment of claims.

- Pay the amount remaining after the amount of the third party's liability has been established; or
- Pay the full amount allowed and seek reimbursement from any liable third party to the limit of legal liability.

Collections vary from $25 million in New York to zero in Montana and Nevada for FY 81. Note should be taken that prior to FY 82 and the changes in the FFP rules established by OBRA, the States had no incentive to report third party collections as a separate line item. As a result, many States netted these amounts out and did not report them in detail.

Table 6.2.2

LOCAL FUNDING FORMULAS FOR MEDICAID VENDOR PAYMENTS
MARCH 31, 1983

COLORADO	20 largest counties pay 2% of State's share for all new ICF nursing home admissions.
FLORIDA	County pays 35% of cost or $55.00 per month, whichever is less, for each nursing home resident; 35% of cost for I/P hospital days over 12 and less than 46; 100% of State share for outpatient services after the first $100 and less than $500 for each recipient.
IOWA	Counties must match Federal funds for ICF-MRs.
MINNESOTA	Counties must pay 10% of State's share.
MONTANA	Counties must pay 18% of eligibility personnel costs.
NEBRASKA	Counties must pay 14% of State's share.
NEW HAMPSHIRE	Counties pay approximately 25% of State's share.
N CAROLINA	Counties pay 15% of State's share for all services except SNFs and ICFs for which they pay 35% of State's share.
N DAKOTA	Counties pay 15% of State share except for ICF-MR, clinic services, and waivered community and home based services for MR related recipients.
PENNSYLVANIA	Counties pay 10% of State's share for county nursing homes plus $3 per invoice administration fee.
S DAKOTA	$60.00 per month for each ICF/MR resident -and local school district for Crippled Childrens' Hospital.
UTAH	Local contribution of less than 1% for specific services, i.e., mental health.
WISCONSIN	Local contribution of 10-20% for specific services, i.e., mental health.

Table 6.2.3

MEDICAID THIRD PARTY COLLECTIONS
FISCAL YEAR 1981

STATE	Collections
ALABAMA	$515,807
ALASKA	$19,725
ARKANSAS	$524,734
CALIFORNIA	$6,466,009
COLORADO	$91,268
CONNECTICUT	$496,851
DELAWARE	$0
DIST COLUMBIA	$269,947
FLORIDA	$2,423,558
GEORGIA	$4,973,314
HAWAII	$352,863
IDAHO	$77,371
ILLINOIS	$1,262,776
INDIANA	$669,861
IOWA	$320,090
KANSAS	$931,933
KENTUCKY	$969,991
LOUISIANA	$157,147
MAINE	$0
MARYLAND	$1,627,772
MASSACHUSETTS	$1,458,091
MICHIGAN	$5,930,551
MINNESOTA	$4,405,764
MISSISSIPPI	$2,566,974
MISSOURI	$121,976
MONTANA	$0
NEBRASKA	$132,706
NEVADA	$0
NEW HAMPSHIRE	$43,832
NEW JERSEY	$763,080
NEW MEXICO	$63,842
NEW YORK	$25,067,404
N CAROLINA	$2,279,256
N DAKOTA	$161,011
OHIO	$773,302
OKLAHOMA	$502,531
OREGON	$187,814
PENNSYLVANIA	$596,820
RHODE ISLAND	$67,582
S CAROLINA	$399,681
S DAKOTA	$255,099
TENNESSEE	$138,915
TEXAS	$37,746
UTAH	$643,590
VERMONT	$161,311
VIRGINIA	$360,954
WASHINGTON	$251,205
W VIRGINIA	$126,584
WISCONSIN	$1,400,163
WYOMING	$18,311

SOURCE: Bureau of Program Operations-HCFA

7. DEMOGRAPHIC, ECONOMIC, AND MEDICAL SECTOR PARAMETERS

Demographic, economic, and medical sector parameters are presented in this section. They place a framework around the Medicaid program characteristics, giving the reader the context within which the Medicaid program operates.

7.1 DEMOGRAPHIC PARAMETERS

Two tables are presented on demographic parameters - total population by State and aged population by State. Table 7.1.1 displays the U.S. population by State, the percent each State is of the total U.S. population, and the percent of each State's population that lives in urban areas for 1980. Additionally, the percent growth of the population from 1970 to 1980 is presented. Alaska and Wyoming are the least populous States with fewer than 500,000 residents. California is the most populous with over 23 million residents and New York follows with 17.6 million residents. Thus, California has over 10 percent of the total U.S. population and Alaska has less than .18 percent of the total population. The percent of each State's population living in urban areas is over 50 percent in 42 States and the District of Columbia. The States with less than 50 percent urban population are ME, MS, NC, ND, SD, VT and WV. Over the past ten years (1970-1980) all States, with the exception of the District of Columbia, New York, and Rhode Island, have had a positive rate of growth. Those with growth rates over 40 percent were Nevada (63.5), Florida (43.4) and Wyoming (41.6).

The aged population by State for 1981 is presented on Table 7.1.2. States with over one million residents aged 65 and older are CA, FL, IL, NY, OH, PA and TX. Alaska has only 13,000 residents aged 65 or older. Twenty States had at least 12 percent of their population aged 65 or older in 1981 as compared to six States in 1975. California has 9.5 percent of the national population aged 65 and over with New York (8.2), Florida (6.7), and Pennsylvania (6.0) following. Thirty-five States each had two percent or less of the aged 65 and over residents. During the time period 1975-1979, Nevada experienced the largest percent growth in aged 65 and older residents at 38.6 percent. Nevada

Table 7.1.1

STATE DEMOGRAPHICS
TOTAL POPULATION

STATE	Population (1980)	Percent Of National Population (1980)	Percent Of Population In Urban Area (1980)	Percent Growth (1970-1980)
ALABAMA	3,890,061	1.72	60.0	12.9
ALASKA	400,481	0.18	64.5	32.5
ARKANSAS	2,285,513	1.01	51.6	18.8
CALIFORNIA	23,668,562	10.45	91.3	18.6
COLORADO	2,888,834	1.28	80.6	30.9
CONNECTICUT	3,107,576	1.37	78.8	2.5
DELAWARE	595,225	0.26	70.7	8.6
DIST COLUMBIA	637,651	0.28	100.0	-15.7
FLORIDA	9,739,992	4.30	84.3	43.4
GEORGIA	5,464,265	2.41	62.3	19.1
HAWAII	965,000	0.43	86.5	25.3
IDAHO	943,935	0.42	54.0	32.4
ILLINOIS	11,418,461	5.04	83.0	2.7
INDIANA	5,490,179	2.42	64.2	5.7
IOWA	2,913,387	1.29	58.6	3.1
KANSAS	2,363,206	1.04	66.7	5.1
KENTUCKY	3,661,433	1.62	50.8	13.7
LOUISIANA	4,203,972	1.86	68.6	15.4
MAINE	1,124,660	0.50	47.5	13.2
MARYLAND	4,216,446	1.86	80.3	7.5
MASSACHUSETTS	5,737,037	2.53	83.8	0.8
MICHIGAN	9,258,344	4.09	70.7	4.3
MINNESOTA	4,077,148	1.80	66.8	7.2
MISSISSIPPI	2,520,638	1.11	47.3	13.7
MISSOURI	4,917,444	2.17	68.1	5.1
MONTANA	786,690	0.35	52.9	13.3
NEBRASKA	1,570,006	0.69	62.7	5.8
NEVADA	799,184	0.35	85.3	63.5
NEW HAMPSHIRE	920,610	0.41	52.2	24.8
NEW JERSEY	7,364,158	3.25	89.0	2.7
NEW MEXICO	1,299,968	0.57	72.2	27.9
NEW YORK	17,557,288	7.75	84.6	-3.8
N CAROLINA	5,874,429	2.59	48.0	15.6
N DAKOTA	652,695	0.29	48.8	5.7
OHIO	10,797,419	4.77	73.3	1.4
OKLAHOMA	3,025,266	1.34	67.3	18.2
OREGON	2,632,663	1.16	67.9	25.9
PENNSYLVANIA	11,866,728	5.24	69.3	0.6
RHODE ISLAND	947,154	0.42	87.0	-0.3
S CAROLINA	3,119,208	1.38	54.1	20.4
S DAKOTA	690,178	0.30	46.4	3.6
TENNESSEE	4,590,750	2.03	60.4	17.0
TEXAS	14,228,383	6.28	79.6	27.1
UTAH	1,461,037	0.65	84.4	37.9
VERMONT	511,456	0.23	33.8	15.0
VIRGINIA	5,346,279	2.36	66.0	15.0
WASHINGTON	4,130,163	1.82	73.6	21.1
W VIRGINIA	1,944,644	0.86	36.2	11.8
WISCONSIN	4,705,335	2.08	64.2	6.5
WYOMING	470,816	0.21	62.8	41.6

SOURCE: Bureau of the Census, U.S. Department of Commerce

Table 7.1.2

STATE AGED POPULATION
(65 AND OLDER)

STATE	Population 65 and Older (1981)	Percent Of State Population 65 and Older (1981)	Percent Of National Population 65 and Older (1981)	Percent Growth In 65 and Older (1975-1979)	Percent Growth In 65 and Older (1980-1982)
ALABAMA	461,000	11.7	1.7	14.0	4.7
ALASKA	13,000	3.0	0.1	25.0	16.1
ARKANSAS	323,000	14.1	1.2	14.0	3.5
CALIFORNIA	2,553,000	10.3	9.5	16.4	5.7
COLORADO	264,000	8.7	1.0	21.3	6.6
CONNECTICUT	387,000	12.3	1.5	13.7	6.0
DELAWARE	63,000	10.5	0.2	18.7	6.2
DIST COLUMBIA	73,000	11.6	0.3	8.9	-1.2
FLORIDA	1,808,000	17.4	6.7	18.2	7.1
GEORGIA	549,000	9.7	2.1	16.1	6.2
HAWAII	85,000	8.6	0.3	18.6	11.4
IDAHO	101,000	10.5	0.4	19.7	8.3
ILLINOIS	1,313,000	11.5	4.9	10.2	4.0
INDIANA	614,000	11.2	4.9	11.5	4.9
IOWA	401,000	13.8	1.5	11.4	3.4
KANSAS	316,000	13.1	1.2	11.0	3.1
KENTUCKY	426,000	11.6	1.6	9.7	3.8
LOUISIANA	419,000	9.6	1.6	12.7	3.7
MAINE	147,000	13.0	0.6	11.5	4.1
MARYLAND	420,000	9.9	1.6	14.4	6.3
MASSACHUSETTS	751,000	13.0	2.8	12.1	3.3
MICHIGAN	964,000	10.6	3.6	12.8	5.7
MINNESOTA	502,000	12.2	1.9	13.8	4.7
MISSISSIPPI	299,000	11.7	1.1	12.1	3.3
MISSOURI	666,000	13.5	2.5	9.1	2.8
MONTANA	90,000	11.2	0.3	15.2	6.7
NEBRASKA	212,000	13.4	0.8	11.4	2.9
NEVADA	77,000	8.7	0.3	38.6	16.7
NEW HAMPSHIRE	109,000	11.5	0.4	16.6	6.2
NEW JERSEY	900,000	12.1	3.4	12.5	4.7
NEW MEXICO	126,000	9.3	0.5	21.1	8.8
NEW YORK	2,198,000	12.5	8.2	8.5	1.7
N CAROLINA	648,000	10.8	2.4	17.0	7.5
N DAKOTA	84,000	12.5	0.3	15.9	4.5
OHIO	1,224,000	11.3	4.6	11.0	4.7
OKLAHOMA	390,000	12.3	1.5	13.4	3.7
OREGON	325,000	12.3	1.2	17.1	7.2
PENNSYLVANIA	1,606,000	13.5	6.0	11.1	4.8
RHODE ISLAND	132,000	13.8	0.5	12.8	4.0
S CAROLINA	310,000	9.7	1.2	18.5	7.8
S DAKOTA	94,000	13.6	0.4	12.5	3.8
TENNESSEE	542,000	11.7	2.0	13.1	4.7
TEXAS	1,442,000	9.4	5.4	16.1	5.2
UTAH	118,000	7.6	0.4	20.4	8.5
VERMONT	60,000	11.6	0.2	14.2	3.7
VIRGINIA	537,000	9.8	2.0	16.1	6.3
WASHINGTON	464,000	10.9	1.7	18.2	7.4
W VIRGINIA	247,000	12.7	0.9	5.6	3.7
WISCONSIN	592,000	12.4	2.2	14.4	4.9
WYOMING	39,000	7.8	0.2	12.5	6.0

SOURCE: Bureau of the Census, U.S. Department of Commerce

was followed by Alaska (25.0), Colorado (21.3), New Mexico (21.1), and Utah (20.4). During the time period 1980-1982, Nevada again experienced the largest percent growth in aged 65 and older residents at 16.7 percent. Alaska (16.1) and Hawaii (11.4) were the only other two States experiencing over a ten percent growth. One jurisdiction, the District of Columbia, had a negative rate of growth (-1.2) for the 1980-1982 time period in the aged 65 and over population.

7.2 ECONOMIC PARAMETERS

Three tables are presented on economic parameters - State economic characteristics, ratio of Medicaid recipients to persons below the poverty line, and average recipients and payments for the AFDC, Foodstamp, and Medicaid programs.

Table 7.2.1 displays State economic characteristics including per capita personal income, and annual unemployment rate, percent of population below poverty, and percent of age 65 and over population below poverty. The U.S. average per capita personal income was $11,056 and it ranged from $7,792 in Mississippi to $15,000 in Alaska for 1982. The U.S. annual unemployment rate for 1982 was 9.7 and it ranged from below 6 percent in North Dakota, South Dakota, Oklahoma, and Wyoming to over 10 percent in eighteen States. The U.S. average percent of population below poverty in 1979 was 12.4. Eight States (AL, AR, DC, KY, LA, MS, and NM) had over 17 percent of their population below the poverty level in 1979. The U.S. average percent of aged (65+) population below poverty was 14.8 in 1979. Of their age 65 and over population thirteen States reported more than 20 percent were below the poverty level in 1979. California (8.3 percent), Connecticut (8.8 percent), Massachusetts (9.7 percent), New Jersey (9.9 percent) and Wisconsin (9.6 percent) had the smallest percent of aged population below the poverty level.

The ratio of Medicaid recipients to persons below the poverty line is displayed on Table 7.2.2. This table shows the rank of each State as well as the average payment per Medicaid recipient and the per capita personal income for 1980. The ratio of Medicaid recipients to individuals living at or below the poverty level ranged from 97 percent in California to 23 percent in South Dakota. The distribution of these percentages is displayed in Figures 3 and 4.

Table 7.2.1

STATE ECONOMIC CHARACTERISTICS

STATE	Per Capita Personal Income (1982)	Annual Unemployment Rate (1982)	Percent Of Population Below Poverty (1979)	Percent Of 65+ Population Below Poverty (1979)
ALABAMA	$8,581	14.40	18.9	28.4
ALASKA	$15,200	9.90	10.7	14.2
ARKANSAS	$8,332	9.80	19.0	28.2
CALIFORNIA	$12,543	9.90	11.4	8.3
COLORADO	$11,776	7.70	10.1	12.8
CONNECTICUT	$13,687	6.90	8.0	8.8
DELAWARE	$11,796	8.50	11.8	13.6
DIST COLUMBIA	$14,347	10.60	18.6	18.9
FLORIDA	$10,875	8.20	13.4	12.7
GEORGIA	$9,514	7.80	16.6	25.6
HAWAII	$11,602	6.70	9.9	10.5
IDAHO	$9,259	9.80	12.6	16.0
ILLINOIS	$12,162	11.30	11.0	11.9
INDIANA	$10,109	11.90	9.7	12.7
IOWA	$10,532	8.50	10.1	13.3
KANSAS	$11,448	6.30	10.1	14.2
KENTUCKY	$8,861	10.60	17.6	23.3
LOUISIANA	$10,083	10.30	18.6	27.7
MAINE	$9,033	8.60	13.0	16.4
MARYLAND	$12,194	8.40	9.3	12.7
MASSACHUSETTS	$11,921	7.90	9.6	9.7
MICHIGAN	$11,052	15.50	10.4	12.2
MINNESOTA	$11,082	7.80	9.5	14.8
MISSISSIPPI	$7,792	11.00	23.9	34.3
MISSOURI	$10,175	9.20	12.2	17.4
MONTANA	$9,750	8.60	12.3	14.4
NEBRASKA	$10,489	6.10	10.7	15.5
NEVADA	$11,748	10.10	8.7	10.7
NEW HAMPSHIRE	$10,710	7.40	8.5	12.3
NEW JERSEY	$13,027	9.00	9.5	9.9
NEW MEXICO	$8,997	9.20	17.6	21.1
NEW YORK	$12,328	8.60	13.4	11.6
N CAROLINA	$9,032	9.00	14.8	23.8
N DAKOTA	$10,746	5.90	12.6	17.0
OHIO	$10,783	12.50	10.3	12.6
OKLAHOMA	$10,776	5.70	13.4	21.0
OREGON	$10,392	11.50	10.7	11.8
PENNSYLVANIA	$10,943	10.90	10.5	11.9
RHODE ISLAND	$10,730	10.20	10.3	12.8
S CAROLINA	$8,468	10.80	16.6	25.3
S DAKOTA	$9,506	5.50	16.9	20.2
TENNESSEE	$8,849	11.80	16.4	25.1
TEXAS	$11,352	6.90	14.7	21.2
UTAH	$8,733	7.80	10.3	11.8
VERMONT	$9,446	6.90	12.1	13.8
VIRGINIA	$11,003	7.70	11.8	17.2
WASHINGTON	$11,635	12.10	9.8	11.3
W VIRGINIA	$8,856	13.90	15.0	18.5
WISCONSIN	$10,497	10.70	8.7	9.6
WYOMING	$11,970	5.80	7.9	14.0
U.S. AVERAGE	$11,056	9.70	12.4	14.8

SOURCE: Per Capita Personal Income- Bureau of Economic Analysis, U.S. Dept. of Commerce.
Annual Unemployment Rate- Bureau of Labor Statistics, U.S. Dept. of Labor.
Poverty Population- Bureau of the Census, U.S. Dept. of Commerce, 1980 Census.

Table 7.2.2

RATIO OF MEDICAID RECIPIENTS TO PERSONS BELOW THE POVERTY LEVEL
RANKED BY STATE

FISCAL YEAR 1980

STATE	Ratio Of Medicaid Recipients To Persons Living Below The Poverty Level*	Average Payment Per Medicaid Recipient**	Per Capita Personal Income***
CALIFORNIA	97	798	10,938
HAWAII	91	902	10,101
MASSACHUSETTS	88	1,302	10,125
RHODE ISLAND	88	1,255	9,444
OREGON	82	646	9,317
NEW YORK	79	1,985	10,260
ALABAMA	75	812	7,488
DIST COLUMBIA	69	1,330	12,039
MARYLAND	69	1,023	10,460
PENNSYLVANIA	68	846	9,434
MAINE	66	902	7,925
NEW JERSEY	65	1,118	10,924
MICHIGAN	63	1,101	9,950
WISCONSIN	59	1,616	9,348
WASHINGTON	58	1,044	10,309
ALASKA	57	1,554	12,790
DELAWARE	57	920	10,339
ILLINOIS	57	1,137	10,521
CONNECTICUT	52	1,615	11,720
MINNESOTA	50	1,814	9,724
S CAROLINA	50	768	7,266
VERMONT	49	1,102	7,827
KENTUCKY	47	721	7,613
OHIO	44	1,001	9,462
KANSAS	43	1,355	9,983
OKLAHOMA	41	1,046	9,116
LOUISIANA	40	1,137	8,458
MISSISSIPPI	40	688	6,580
NEW HAMPSHIRE	40	1,603	9,131
IOWA	39	1,290	9,358
COLORADO	38	1,286	10,005
ARKANSAS	36	1,054	7,268
TENNESSEE	36	1,071	7,720
MONTANA	35	1,361	8,536

Table 7.2.2 (Con't)

RATIO OF MEDICAID RECIPIENTS TO PERSONS BELOW THE POVERTY LEVEL
RANKED BY STATE

FISCAL YEAR 1980

STATE	Ratio Of Medicaid Recipients To Persons Living Below The Poverty Level*	Average Payment Per Medicaid Recipient**	Per Capita Personal Income***
VIRGINIA	35	1,120	9,392
GEORGIA	34	1,075	8,073
MISSOURI	33	918	8,982
IDAHO	32	1,182	8,056
UTAH	32	1,387	7,649
W VIRGINIA	32	801	7,800
WYOMING	32	1,307	10,898
NEW MEXICO	31	800	7,841
N CAROLINA	30	1,065	7,819
NEVADA	29	1,781	10,727
FLORIDA	28	783	8,996
INDIANA	27	1,726	8,936
N DAKOTA	26	1,489	8,747
TEXAS	25	1,426	9,545
NEBRASKA	24	1,526	9,365
S DAKOTA	23	1,575	7,806

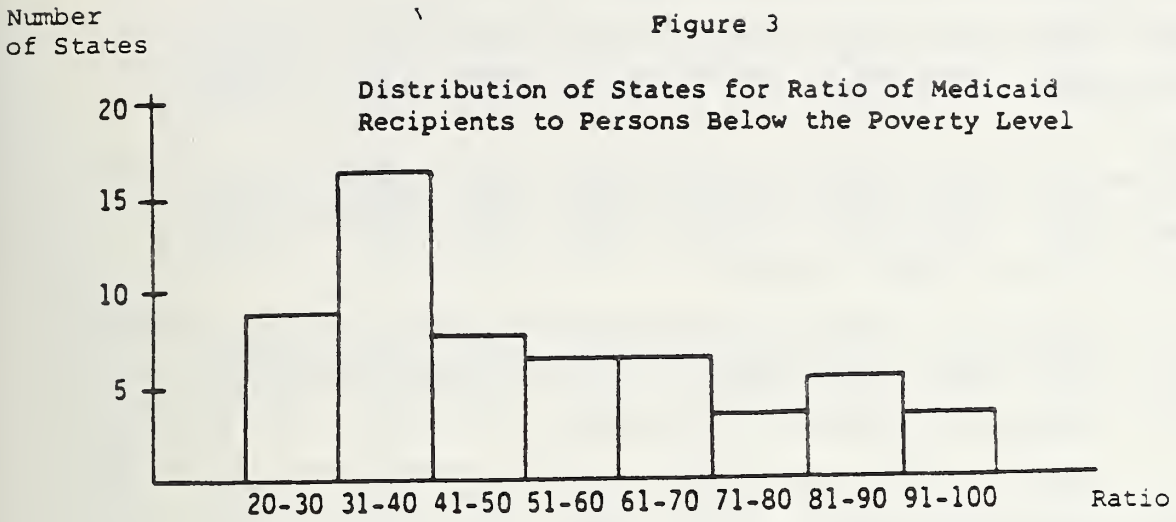
SOURCE: Medicaid Data - Medicaid Statistics Branch, BDMS, HCFA; Income Data - Survey of Current Business, U.S. Dept of Commerce, Vol. 60, No. 8, August 1980.

* Numerator data were calculated from data submitted by the States to HCFA. Data from four States were estimated from 1980 data and data from Pennsylvania were adjusted due to a sampling problem. The numerator includes an estimate of the total number of persons receiving Medicaid services in each State regardless of whether Federal monies were involved. Denominator data were developed from U.S. Bureau of Census data provided by the Office of the Deputy Assistant Secretary for Planning and Evaluation/Health, DHHS. The demoninator was adjusted to include an estimate of those receiving Medicaid who were not poor.

** This average was calculated by dividing total expenditures, exclusive of non-Medicaid recipient payments, by the total number of Medicaid recipients as reported to HCFA.

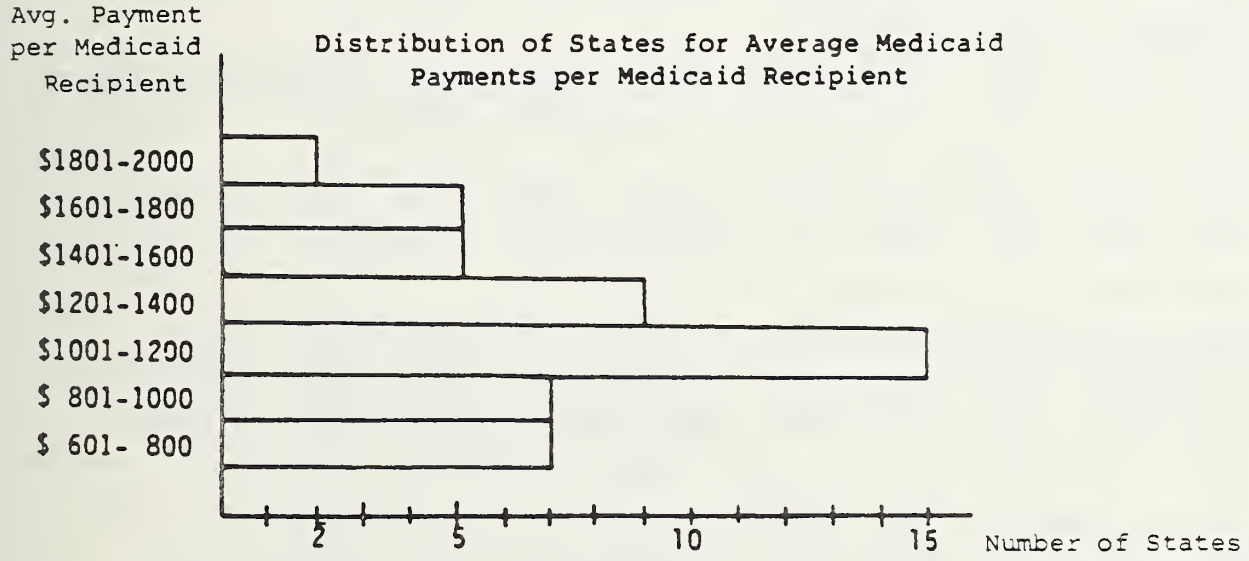
*** Per capita personal income is for CY 1979.

Figure 3



The average Medicaid payment per Medicaid recipient for 1980 ranges from $646 in Oregon to $1,985 in New York. The distribution of average Medicaid payments per Medicaid recipient is displayed below.

Figure 4



Per capita personal income is also found on Table 7.2.2 showing a range from $6,580 in Mississippi to $12,790 in Alaska.

The average recipients and payments for one month for the AFDC program, the Foodstamp program, and the Medicaid program are shown on Table 7.2.3. The Medicaid data are for March 1983 and include total reported payments, total reported recipients, and average payment per recipient. Total reported payments ranged from $2.8 million in Wyoming to $502.5 million in New York. Total reported recipients ranged from less than 6,000 in Wyoming to 1.5 million in California. The average Medicaid payment per recipient ranged from $139 in West Virginia to $536 in Wyoming.

AFDC total payments for an average month in 1982 ranged from $720 thousand in Wyoming to $228 million in California. The total number of AFDC recipients ranged from less than six thousand in Wyoming to 1.5 million in California. The average monthly payment per AFDC recipient ranged from $30.48 in Mississippi to $209.83 in Alaska.

Total payments for the Foodstamps program for March 1983 ranged from $1.1 million in Wyoming to $78.4 million in New York. The total number of Foodstamp recipients ranged from 27.5 thousand in Wyoming to 1.9 million in New York. The average payment per Foodstamp recipient falls in the range of $30 - $50 for all States with the exception of Alaska ($70), Hawaii ($68), and Nevada ($52).

7.3 MEDICAL SECTOR PARAMETERS

Three tables are presented in this section showing the supply of Medical services for Medicaid populations including the enrolled and participating physicians and Medicaid-certified beds. Table 7.3.1 displays the number of physicians enrolled and participating, the basis of the file of physicians (individuals or individuals and groups), and the date of the last file update. Enrolled physicians are generally defined to be those physicians who have applied for and received a Medicaid provider number. Participating physicians are generally defined to be those physicians who have submitted at least one claim within the past 12-month period. The number of physicians enrolled ranged from 796 in Alaska to 55,960 in California while the number of physicians participating ranged from 601 in North Dakota to 27,076 in New York. While the absolute numbers of physicians enrolled and participating serve as an indicator of access to medical care it is important to note

Table 7.2.3

AFDC, FOODSTAMP AND MEDICAID PROGRAM
AVERAGE RECIPIENTS AND PAYMENTS PER MONTH

STATE	MEDICAID (March 1983) Total Reported Payments	Total Reported Recipients	Average Payment Per Recipient	AFDC (Average Month, 1982) Total Payments	Total Recipients	Payment Per Recipient	FOODSTAMPS (March 1983) Total Payments	Total Recipients	Payment Per Recipient
ALABAMA	$35,709,985	154,063	$218.81	$5,997,236	156,038	$38.43	$29,408,000	680,980	$43.18
ALASKA	**	**	**	$2,690,003	12,828	$209.83	$2,808,080	28,400	$70.42
ARKANSAS	$31,510,864	109,745	$287.13	$2,839,349	67,612	$41.99	$13,400,000	330,600	$40.53
CALIFORNIA	$373,072,022	1,515,094	$246.77	$227,831,634	1,522,398	$149.65	$63,808,800	1,829,600	$34.99
COLORADO	$24,282,265	73,729	$329.35	$7,218,083	79,814	$99.21	$9,100,008	203,200	$44.78
CONNECTICUT	$41,633,025	114,219	$364.50	$17,517,379	127,475	$137.42	$6,400,000	179,300	$36.91
DELAWARE	$4,895,211	18,599	$263.20	$2,359,406	28,076	$84.04	$2,500,008	54,100	$46.21
DIST COLUMBIA	$21,914,719	43,192	$507.38	$7,202,662	64,685	$111.35	$4,000,000	88,600	$45.15
FLORIDA	$56,515,620	266,626	$211.97	$17,212,301	259,793	$66.25	$38,700,000	835,900	$46.30
GEORGIA	$52,695,936	221,953	$237.42	$14,330,048	230,505	$62.17	$28,000,000	642,000	$43.61
HAWAII	$12,148,623	44,516	$272.91	$7,322,919	56,135	$130.45	$6,900,000	101,900	$67.71
IDAHO	$5,727,296	17,727	$323.08	$1,675,879	17,479	$95.88	$3,700,000	77,100	$47.99
ILLINOIS	$147,094,024	513,427	$286.50	$66,850,849	711,699	$93.93	$56,700,800	1,149,700	$49.32
INDIANA	$54,314,831	113,808	$477.25	$11,613,275	156,620	$74.15	$23,900,000	522,900	$45.71
IOWA	$25,101,349	94,320	$266.13	$10,579,107	90,624	$116.74	$9,100,000	219,900	$41.38
KANSAS	$20,959,764	66,301	$316.13	$6,763,163	63,775	$106.05	$6,200,000	144,100	$43.03
KENTUCKY	$47,464,267	185,567	$255.78	$10,219,085	148,430	$68.85	$29,500,000	598,000	$49.33
LOUISIANA	$58,347,593	176,904	$329.83	$10,597,590	192,202	$55.14	$26,000,000	603,600	$43.08
MAINE	$15,349,935	58,272	$263.42	$4,894,961	49,557	$98.77	$6,300,000	140,200	$44.94
MARYLAND	$43,490,303	149,919	$290.09	$17,753,639	197,019	$98.11	$15,300,000	326,900	$46.80
MASSACHUSETTS	$106,976,209	324,470	$329.70	$39,028,952	285,904	$136.51	$16,900,000	376,900	$44.84
MICHIGAN	$152,603,449	552,424	$276.24	$88,691,829	726,839	$122.02	$49,400,000	1,117,500	$44.21
MINNESOTA	$65,086,180	144,387	$456.32	$19,572,553	133,824	$146.26	$9,200,000	252,500	$36.44
MISSISSIPPI	$26,492,134	156,961	$168.78	$4,604,575	151,088	$30.48	$23,500,000	550,000	$42.73
MISSOURI	$36,857,778	154,473	$238.60	$14,620,874	182,434	$88.14	$20,000,000	454,000	$44.05
MONTANA	$8,180,425	22,136	$369.91	$1,576,837	16,092	$97.99	$2,500,000	60,100	$41.60
NEBRASKA	$14,736,346	41,703	$353.36	$4,057,380	37,196	$109.08	$3,800,000	99,300	$38.27
NEVADA	$6,329,653	12,257	$516.41	$1,003,966	12,974	$77.38	$2,000,000	38,800	$51.55
NEW HAMPSHIRE	$7,623,895	19,595	$389.07	$2,038,701	20,102	$101.42	$2,400,008	51,100	$46.97
NEW JERSEY	$76,908,735	282,448	$272.29	$42,767,322	412,105	$103.78	$27,208,000	560,900	$48.49
NEW MEXICO	$8,880,282	35,533	$347.80	$3,709,615	50,569	$73.36	$8,500,000	190,400	$44.64
NEW YORK	$502,458,049	1,067,746	$470.58	$136,773,364	1,075,205	$127.21	$78,400,000	1,900,400	$41.26
N CAROLINA	$47,823,371	152,584	$313.42	$11,916,975	173,434	$68.71	$23,800,000	585,700	$40.64
N DAKOTA	$7,438,445	16,166	$460.13	$1,196,976	10,827	$110.55	$1,400,000	35,700	$39.22
OHIO	$130,007,153	443,331	$293.29	$50,556,918	587,283	$86.09	$57,500,000	1,209,000	$47.56
OKLAHOMA	$48,474,648	102,026	$475.12	$6,164,645	70,306	$87.68	$10,000,000	260,700	$38.36
OREGON	$20,808,293	113,412	$183.48	$8,344,652	77,196	$108.10	$14,600,000	300,700	$48.55
PENNSYLVANIA	$121,830,455	455,796	$267.29	$61,671,910	601,038	$102.61	$47,900,000	1,141,000	$41.98
RHODE ISLAND	$17,351,392	46,773	$370.97	$5,811,222	49,323	$117.82	$3,700,000	83,408	$44.37
S CAROLINA	$26,232,275	122,498	$214.15	$6,309,593	139,415	$45.26	$19,600,000	460,700	$42.54
S DAKOTA	$7,351,440	16,692	$440.42	$1,393,110	16,347	$85.22	$2,400,000	54,900	$43.72
TENNESSEE	$45,439,346	168,832	$269.14	$6,202,900	146,579	$42.32	$28,700,000	648,900	$44.23
TEXAS	$113,758,736	363,977	$312.54	$9,852,428	285,206	$34.55	$61,400,000	1,372,600	$44.73
UTAH	$9,977,851	27,221	$366.55	$3,951,771	35,442	$111.50	$3,900,000	95,900	$40.67
VERMONT	$7,886,168	28,791	$273.91	$3,139,139	22,231	$141.21	$2,400,000	55,200	$43.48
VIRGINIA	$41,173,694	146,501	$281.05	$13,794,514	158,710	$86.92	$19,800,000	467,300	$42.37
WASHINGTON	$22,466,844	109,679	$204.84	$19,961,998	136,975	$145.73	$13,100,000	316,000	$41.46
W VIRGINIA	$8,238,979	59,395	$138.72	$4,696,425	72,409	$64.86	$13,000,000	302,800	$49.93
WISCONSIN	$72,451,980	222,569	$325.53	$33,867,950	241,781	$140.08	$12,600,000	372,900	$33.79
WYOMING	$2,848,949	5,314	$536.12	$719,617	5,990	$120.13	$1,100,000	27,500	$40.00

** Not Reported

SOURCE: Medicaid data-HCFA 120. AFDC Office of Family Assistance, DHHS. Food Stamp data-Food and Nutrition Service, USDA.

Table 7.3.1

ENROLLED AND PARTICIPATING PHYSICIANS

	Number of Physicians		File Based on		Date of Last File Update
	Enrolled	Participating	Individuals	Individuals and Groups	
ALABAMA	4,000	3,700	X	-	1980
ALASKA	796	**	-	X	1983
ARKANSAS	4,797	3,598	-	X	1983
CALIFORNIA	55,960	25,679	-	X	1983
COLORADO	10,314	5,416	X	-	**
CONNECTICUT	**	**	**	**	**
DELAWARE	**	**	**	**	**
DIST COLUMBIA	**	**	**	**	**
FLORIDA	18,000	10,000	-	X	1982
GEORGIA	13,008	10,000	X	-	1983
HAWAII	**	**	**	**	**
IDAHO	3,047	1,539	-	X	1980
ILLINOIS	18,513	**	X	-	1983
INDIANA	9,595	5,040	-	X	1983
IOWA	5,521	3,967	-	X	1983
KANSAS	**	**	**	**	**
KENTUCKY	12,298	5,149	-	X	1983
LOUISIANA	**	**	**	**	**
MAINE	3,110	1,586	-	X	1983
MARYLAND	**	4,393	-	X	1982
MASSACHUSETTS	13,110	**	X	-	**
MICHIGAN	14,836	**	-	X	1981
MINNESOTA	**	**	**	**	**
MISSISSIPPI *	7,483	2,503	X	-	1979
MISSOURI	10,048	2,800	-	X	1979
MONTANA	**	**	**	**	**
NEBRASKA	5,100	4,050	-	X	1980
NEVADA	3,179	1,568	X	-	1981
NEW HAMPSHIRE	1,122	1,089	-	X	1983
NEW JERSEY	29,249	9,196	E	P	1982
NEW MEXICO	3,089	1,213	-	X	None
NEW YORK	29,934	27,076	-	X	**
N CAROLINA	6,000	2,945	-	X	1983
N DAKOTA	1,920	601	E	P	1982
OHIO	14,410	**	-	X	1983
OKLAHOMA *	17,500	**	X	-	1983
OREGON	4,284	4,284	X	-	1983
PENNSYLVANIA	16,692	12,815	-	X	**
RHODE ISLAND	1,355	1,355	-	X	1983
S CAROLINA	5,115	3,530	-	X	1979
S DAKOTA	**	**	X	-	1983
TENNESSEE	**	**	**	**	**
TEXAS	24,439	12,525	-	X	1983
UTAH	3,652	2,931	-	X	1983
VERMONT	1,200	800	-	X	1982
VIRGINIA	7,269	6,283	X	-	1982
WASHINGTON	4,804	3,572	-	X	1982
W VIRGINIA	3,657	2,430	-	X	1983
WISCONSIN	9,694	5,451	-	X	**
WYOMING	**	**	**	**	**

KEY: E = Enrolled P = Participating
* Includes Out of State Physicians
** Data Not Available

whether the physician file is based on individual physicians or individual and group practices. Eleven States base their enrolled and participating files on individuals. Twenty-seven States base their enrolled and participating files on individuals and group practices. Two States, New Jersey and North Dakota, base their enrolled file on individuals and their participating file on individuals and group practices. The date of the last file update also affects the numbers of enrolled and participating physicians. Nineteen States had updated files as of 1983 while three States updated as of 1979 and one State had deleted only those physicians who had died.

Table 7.3.2 displays the number of Medicaid certified beds by category. The smallest number of inpatient beds were reported in Arkansas with 522 while the largest number was reported in California with 93,198. Only nine States reported any Medicaid certified swing beds and the numbers of those beds were small with a range of six in Arkansas to 398 in North Dakota. Long-term care beds were reported in six categories: SNF Medicaid certified, SNF dually certified, ICF, ICR-MR, SNF/ICF Medicaid certified, and SNF/ICF dually certified. The number of SNF Medicaid certified beds ranged from zero in 19 States to 23,930 in Pennsylvania and the number of SNF dually certified beds ranged from zero in six States to 84,161 in California. Medicaid certified ICF beds ranged from 27 in Alaska to 83,603 in Texas. ICF-MR beds were available in all reporting States and ranged in number from 132 in Alaska to 17,917 in New York. SNF/ICF Medicaid certified beds were reported by five States with a range of 9220 in New Jersey to 34,614 in Wisconsin. SNF/ICF dually certified beds were reported by 24 States with a range of 30 in Kentucky to 47,415 in Illinois.

Table 7.3.3 presents the enrolled and participating physicians per 1000 Medicaid recipients, the acute care hospital beds per 1000 Medicaid recipients, and the total long-term care beds per 1000 aged 65 and over Medicaid recipients. The number of enrolled physicians per 1000 Medicaid recipients ranged from 10.93 in Rhode Island to 110.95 in Nevada while the number of participating physicians per 1000 Medicaid recipients ranged from 6.85 in California to 54.72 in Nevada. Acute care hospital beds per 1000 Medicaid recipients ranged from 2.65 in Arkansas to 126.8 in Nevada. The number of total long-term care beds per 1000 aged 65 and over Medicaid recipients ranged from 62.5 in Alaska to 960.63 in North Dakota.

Table 7.3.2

MEDICAID CERTIFIED BEDS

STATE	I/P Acute	Swing Beds	SNF Medicaid Certified	SNF Dually Certified	ICF	ICF-MR	SNF/ICF Medicaid Certified	SNF/ICF Dually Certified
ALABAMA	21,128	***	86	10,221	5,953	1,523	0	4,480
ALASKA	1,113	6	0	242	27	132	0	64
ARKANSAS	522	0	10,155	291	10,042	1,473	0	0
CALIFORNIA	93,198	***	16,052	84,161	2,088	464	0	2,690
COLORADO	12,928	0	8,190	7,450	1,676	3,538	0	15,640
CONNECTICUT	***	***	***	***	***	***	***	***
DELAWARE	***	***	***	***	***	***	***	***
DIST COLUMBIA	***	***	***	***	***	***	***	***
FLORIDA	54,060	0	318	0	1,419	2,719	34,240	0
GEORGIA	25,098	0	22,707	26,714	5,753	2,683	0	32,467
HAWAII	***	***	***	***	***	***	***	***
IDAHO	3,416	0	0	0	189	543	0	4,425
ILLINOIS	57,500	***	0	194	36,443	4,272	0	47,415
INDIANA	24,063	0	301	8,645	36,407	2,135	0	0
IOWA	20,586	0	47	438	29,490	1,902	0	79
KANSAS	***	***	***	***	***	***	***	***
KENTUCKY	17,939	8	0	3,823	14,236	1,283	0	30
LOUISIANA	***	***	***	***	***	***	***	***
MAINE	4,960	0	0	404	8,769	662	0	0
MARYLAND	20,205	0	0	9,926	10,899	2,834	0	389
MASSACHUSETTS	27,247	0	13,024	5,715	27,696	4,051	0	0
MICHIGAN	40,169*	0	11,285	17,978	8,893	4,525	0	7,396
MINNESOTA	***	***	***	***	***	***	***	***
MISSISSIPPI	13,003	40	1,954	0	1,546	1,503	9,769	595
MISSOURI	29,631	265	0	178	12,700	1,789	8,839	5,833
MONTANA	***	***	***	***	***	***	***	***
NEBRASKA	8,366	80	2,134	575	15,320	1,040	0	***
NEVADA	3,633	0	0	0	340	291	0	2,036
NEW HAMPSHIRE	3,198	5	0	566	6,190	340	0	0
NEW JERSEY	33,003	2,567**	0	86	3,104	3,988	9,220	18,017
NEW MEXICO	4,105	***	0	279	3,530	632	0	***
NEW YORK	78,021	0	193	71,611	25,147	17,917	0	0
N CAROLINA	28,285	0	0	9,397	11,145	2,687	0	0
N DAKOTA	3,878	398	4,353	2,867	2,404	348	0	4,353
OHIO	***	0	0	413	27,207	6,712	0	42,235
OKLAHOMA	1,923	0	0	415	28,612	2,197	0	239
OREGON	10,023	332	8,018	3,628	8,244	2,034	0	4,875
PENNSYLVANIA	62,706	0	23,930	32,847	15,718	8,835	0	***
RHODE ISLAND	3,462	0	2,266	2,266	6,337	1,021	0	0
S CAROLINA	12,758	0	152	7,150	4,007	2,638	0	7,150
S DAKOTA	***	***	***	***	***	***	***	***
TENNESSEE	***	***	***	***	***	***	***	***
TEXAS	***	***	11,045	1,873	83,603	3,944	0	***
UTAH	4,876	***	0	0	2,861	350	0	2,233
VERMONT	***	***	***	***	***	***	***	***
VIRGINIA	23,795	0	0	1,804	22,565	882	0	0
WASHINGTON	***	15	0	11,534	1,461	2,993	0	11,619
W VIRGINIA	***	0	0	0	3,769	167	0	3,518
WISCONSIN	24,510	0	0	504	3,987	3,586	34,614	11,145
WYOMING	***	***	***	***	***	***	***	***

KEY: * Excludes State And Federal Institutions
** Not swing beds but I/P Hospital Based Long Term Care Beds
*** Data Not Available

Table 7.3.3

SUPPLY OF MEDICAL SERVICES FOR MEDICAID POPULATIONS

STATE	Physicians Per 1000 Medicaid Recipients Enrolled	Physicians Per 1000 Medicaid Recipients Participating	Hospital Beds Certified Per 1000 Medicaid Recipients	Total Long-Term Care Beds Per 1000 Aged 65 and Over Medicaid Recipients
ALABAMA	12.43	11.49	65.66	142.87
ALASKA	31.01	**	43.36	62.50
ARKANSAS	24.42	18.32	2.65	225.09
CALIFORNIA	14.93	6.85	24.86	93.58
COLORADO	71.79	37.70	89.99	664.90
CONNECTICUT	**	**	**	**
DELAWARE	**	**	**	**
DIST COLUMBIA	**	**	**	**
FLORIDA	34.60	19.22	103.93	187.61
GEORGIA	29.71	22.84	57.34	477.93
HAWAII	**	**	**	**
IDAHO	76.44	38.61	85.70	419.26
ILLINOIS	17.40	**	54.06	414.58
INDIANA	40.26	21.14	100.96	671.83
IOWA	30.74	22.08	114.62	653.44
KANSAS	**	**	**	**
KENTUCKY	34.88	14.60	50.88	163.12
LOUISIANA	**	**	**	**
MAINE	24.46	12.47	39.02	257.39
MARYLAND	**	13.59	62.51	334.25
MASSACHUSETTS	19.57	**	40.68	324.54
MICHIGAN	12.62	**	34.19	236.01
MINNESOTA	**	**	**	**
MISSISSIPPI	24.64	8.24	42.82	123.47
MISSOURI	29.73	8.28	87.67	257.13
MONTANA	**	**	**	**
NEBRASKA	65.61	52.10	107.63	797.35
NEVADA	110.95	54.72	126.80	236.77
NEW HAMPSHIRE	25.61	24.86	73.00	476.56
NEW JERSEY	45.96	14.45	51.86	276.61
NEW MEXICO	34.10	13.39	45.32	156.60
NEW YORK	12.72	11.50	33.15	161.26
N CAROLINA	16.95	8.32	79.93	188.34
N DAKOTA	61.75	19.32	124.72	960.63
OHIO	16.40	**	**	407.72
OKLAHOMA	72.11	**	7.92	374.87
OREGON	25.85	25.85	60.48	745.18
PENNSYLVANIA	15.19	11.66	57.09	316.13
RHODE ISLAND	10.93	10.93	27.94	226.00
S CAROLINA	20.44	14.11	51.00	215.82
S DAKOTA	**	**	**	**
TENNESSEE	**	**	**	**
TEXAS	36.13	18.52	**	291.96
UTAH	61.31	49.20	81.85	414.08
VERMONT	22.12	14.75	**	**
VIRGINIA	22.78	19.69	74.59	228.69
WASHINGTON	18.98	14.11	**	257.27
W VIRGINIA	20.51	13.63	**	140.96
WISCONSIN	21.08	11.85	53.30	529.11
WYOMING	**	**	**	**

SOURCE: Medicaid Recipients - HCFA 2082.
** Indicates Data Not Available or Not Reported

8. STATE-ONLY PROGRAMS

Some States elect to cover specified groups of individuals for Medicaid services entirely at their own expense. These groups are referred to as non-categorically medically needy or, more commonly, "State-only" eligibles. State-only program data are very difficult to obtain and report given the unique characteristics of these programs. Hence, the information presented below is not definitive; however, it will give the reader some flavor of the scope of the programs:

- Administration - The State-only program is administered on a State level in most States. However, in some States it is administered on a county level.

  - When the program is administered on a State level, it is most likely to be administered by the welfare department rather than the single State agency administering the Medicaid program. The personnel in one department are not familiar with the programs in other departments; thus it is difficult to collect data.

  - When the program is administered on a county level, frequently the eligibility requirements and services offered are based on county decision. Thus, there may be no uniform eligibility groups or services across one State. For example, in Arkansas the State-only program is offered to individuals who use out-of-State hospital facilities in a 50 mile radius from the border of Arkansas.

- Eligibility - In general, the most widely covered groups are the indigent and the general assistance recipients, both cash and non-cash. Other groups covered include pensioners, patients in State and local hospitals, the aged, people in transit, foster children, remedial blind, persons with catastrophic illness, and individuals qualifying for food stamps. Eligibility requirements vary widely by group by State/County.

- Benefits - The services range from "home health services" only to the "same services as provided to the categorically needy." In addition to the variance in services covered, there is also variance in the limitations on those services. Thus, benefits vary greatly across eligibility groups within a State and across States.

- Expenditure Data - Expenditures in some States are accounted for by eligibility group and in other States by service. Frequently, when State-only programs are administered on the County level, there is no information available on expenditures on the State level. Some States have only appropriation data.

The uniqueness of each State-only program complicates the data collection and display of data; however, Table 8.1 does present data on State-only programs. Thirty-seven States reported the presence of a State-only program. The number of recipients of medical assistance covered by this program ranged from 89 in Nebraska to 214,094 in Pennsylvania. The total 1981 expenditures ranged from $40,000 in Wyoming to $713,700,000 in California.

The data were collected from two sources. The State reported data were included. However, if the State did not report and information was available via the HCFA-120 monthly report, that information was included. These data are not necessarily comparable to the data on Table 8.1 in the 1982 Medicaid Program Characteristics book due to the use of different sources and also because these data, more than any other, seem to vary by State.

Table 8.1
STATE ONLY PROGRAMS

STATE	Presence Of Program	Total Number Of Recipients (1982)	Total 1982 Expenditures (in millions)
ALABAMA	-	-	-
ALASKA	X	**	$14.10
ARKANSAS	X	**	$1.48
CALIFORNIA	X	168,490	$713.70
COLORADO	X	**	$45.00
CONNECTICUT	-	-	-
DELAWARE	-	-	-
DIST COLUMBIA	X	**	**
FLORIDA	X	**	**
GEORGIA	-	-	-
HAWAII	X	**	$20.22
IDAHO	X	**	**
ILLINOIS	X	131,186	$91.71
INDIANA	-	-	-
IOWA	-	-	-
KANSAS	X	**	$27.82
KENTUCKY	-	-	-
LOUISIANA	X	**	$3.71
MAINE	X	1,103	$0.53
MARYLAND	X	56,969	$78.76
MASSACHUSETTS	X	23,217	$4.74
MICHIGAN	X	20,138	$17.40
MINNESOTA	X	**	**
MISSISSIPPI	-	-	-
MISSOURI	X	5,153	$22.30
MONTANA	X	**	$2.51
NEBRASKA	X	89	$0.76
NEVADA	-	-	-
NEW HAMPSHIRE	-	-	-
NEW JERSEY	X	19,069	$11.64
NEW MEXICO	X	90	$0.17
NEW YORK	X	316,000	$470.56
N CAROLINA	X	**	$2.30
N DAKOTA	X	**	$0.05
OHIO	-	-	-
OKLAHOMA	-	-	-
OREGON	X	**	$14.82
PENNSYLVANIA	X	214,094	$276.26
RHODE ISLAND	X	6,461	$9.81
S CAROLINA	X	**	$1.83
S DAKOTA	X	95	$0.32
TENNESSEE	-	-	-
TEXAS	X	**	$5.51
UTAH	X	3,202	$2.85
VERMONT	X	**	**
VIRGINIA	X	**	**
WASHINGTON	X	11,680	$4.30
W VIRGINIA	X	**	$0.47
WISCONSIN	X	7,608	$4.73
WYOMING	X	**	$0.04
TOTAL	37	984,644	$1,850.40

** Indicates Data Not Available or Not Reported

APPENDICES

APPENDIX I

ACRONYMS

AABD	Aid to Aged, Blind, and Disabled
AB	Aid to the Blind
AFDC	Aid to Families with Dependent Children
APTD	Aid to the Permanently and Totally Disabled
ARF	Area Resource File
CFR	Code of Federal Regulations
CPR	Customary Prevailing, and Reasonable (charges)
CPT	Current Procedural Terminology
DHHS	Department of Health and Human Services
DRGs	Diagnostic Related Groupings
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
FFP	Federal Financial Participation
FY	Fiscal Year
HCFA	Health Care Financing Administration
HMO	Health Maintenance Organization
ICF	Intermediate Care Facility
ICF-MR	Intermediate Care Facility for the Mentally Retarded
MAC	Maximum Allowable Cost
MMIS	Medicaid Management Information System
MQC	Medicaid Quality Control
NMCUES	National Medicare Care Utilization and Expenditure Survey
NP	Nurse Practitioner

OAA	Old Age Assistance
OASDI	Old Age, Survivors, and Disability Insurance
OBRA	Omnibus Reconciliation Act - 1981
ORD	Office of Research and Demonstrations
OT	Occupational Therapy
OTC	Over-the-Counter (drugs)
PCF	Program Characteristics File
PA	Physician's Assistant
PT	Physical Therapy
RHC	Rural Health Clinic
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	Supplemental Security Income
SSP	State Supplemental Payments
TDOC	Total Days of Care
TEFRA	Tax Equity and Fiscal Responsibility Act
UCR	Usual, Customary and Reasonable (charges)

APPENDIX II

GLOSSARY OF MEDICAID TERMS

- Capitation (fee): fee the agency pays periodically to a contractor for each recipient enrolled under a contract for the provision of medical services under the State plan, whether or not the recipient receives the services during the period covered by the fee.

- Categorically Needy: Under Medicaid, categorically needy cases are aged, blind, or disabled individuals or families and children who are otherwise eligible for Medicaid and who meet financial eligibility requirements for AFDC, SSI, or an optional State supplement.

- Copayment: Copayments are a type of cost-sharing under Medicaid whereby insured or covered persons pay a specified flat amount per unit of service or unit of time, and the insurer pays the rest of the cost.

- Covered Services: Covered services are the specific services and supplies for which Medicaid will provide reimbursement. Covered services under the Medicaid program consist of a combination of mandatory and optional services within each State.

- Customary, Prevailing, and Reasonable Charges: Method of reimbursement used under Medicare which limits payment to the lowest of the following: a physician's actual charge, the physician's median charge in a recent prior period (customary), or the 75th percentile of charges in that same time period (prevailing).

- Customary Charge: The charge a physician or supplier usually bills his patients for furnishing a particular service or supply is called the customary charge.

- Diagnosis Related Groups: These groupings are used for incorporating severity of illness measurements into the process for prospective payment determination for inpatient hospital services.

- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT): The EPSDT program covers screening and diagnostic services to determine physical or mental defects in recipients under age 21, and health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered.

- Essential Spouse: One who is living with an aged, blind, or disabled individual who was receiving cash assistance and whose needs were included in determining the amount of cash payment to the individual under OAA, AB, APTD, or AABD; and who is determined essential to the individual's well-being.

- Expenditure: Under Medicaid, expenditure refers to an amount paid out by a State agency for the covered medical expenses of eligible participants.

- Family Planning Services: Family planning services are any medically approved means, including diagnosis, treatment, drugs, supplies and devices, and related counseling which are furnished or prescribed by or under the supervision of a physician for individuals of child-bearing age for purposes of enabling such individuals freely to determine the number or spacing of their children.

- Fiscal Agent: A fiscal agent is a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

- Home Health Agency: A home health agency is a public agency or private organization which is primarily engaged in providing skilled nusring services and other therapeutic services in the patient's home, and which meets certain conditions designed to ensure the health and safety of the individuals who are furnished these services.

- Home Health Services: Home health services are services and items furnished to an individual who is under the care of a physician by a home health agency, or by others under arrangements made by such agency. The services are furnished under a plan established and periodically reviewed by a physician. The services are provided on a visiting basis in an individual's home and include: part-time or intermittent skilled nursing care; physical, occupational, or speech therapy; medical social services, medical supplies and appliances (other than drugs and biologicals); home health aide services, and services of interns and residents.

- Inpatient Hospital Services: Inpatient hospital services are items and services furnished to an inpatient of a hospital by the hospital, including bed and board, nursing and related services, diagnostic and therapeutic services, and medical or surgical services.

- Intermediate Care Facility: An intermediate care facility is an institution furnishing health-related care and services to individuals who do not require the degree of care provided by hospitals or skilled nursing facilities as defined under Title XIX (Medicaid) of the Social Security Act.

- Laboratory and Radiological Services: Laboratory and radiological services are professional and technical laboratory and radiological services ordered by a licensed practitioner and provided in an office or similar facility (other than a hospital outpatient department or clinic) or by a qualified laboratory.

- Medically Needy: Under Medicaid, medically needy cases are aged, blind, or disabled individuals or families and children who are otherwise eligible for Medicaid, and whose income resources are above the limits for eligibility as categorically needy (AFDC or SSI) but are within limits set under the Medicaid State plan.

- Medicare Principles: rules of reasonable cost-based reimbursement used by Medicare.

- Other Practitioners' Services: Other practitioners' services are health care services of licensed practitioners other than physicians and dentists.

- Outpatient Hospital Services: Outpatient hospital services are services furnished to outpatients by a participating hospital for diagnosis or treatment of an illness or injury.

- Portable X-ray: A portable X-ray is a radiograph taken with portable equipment, usually in the patient's place of residence, under the general supervision of a physician.

- Prescribed Drugs: Prescribed drugs are drugs dispensed by a licensed pharmacist on the prescription of a practitioner licensed by law to administer such drugs, and drugs dispensed by a licensed practitioner to his own patients. This item does not include a practitioner's drug charges that are not separable from his other charges, or drugs covered by a hospital's bill.

- Prevailing Charge: The prevailing charge is the charge that would cover 75 percent of the customary charges made for similar services in the same locality.

- Psychiatric Hospital: A psychiatric hospital is an institution primarily engaged in providing to inpatients, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mental illness.

- Reasonable Charge: In processing claims for Supplementary Medical Insurance benefits, carriers use HCFA guidelines to establish the reasonable charge for services rendered. The reasonable charge is the lowest of: the actual charge billed by the physician or supplier; the charge the physician or supplier customarily bills his patients for the same service; and the prevailing charge which most physicians or suppliers in that locality bill for the same service. Increases in the physicians' prevailing charge levels are recognized only to the extent justified by an index reflecting changes in the costs of practice and in general earnings.

- Reasonable Cost: In processing claims for Health Insurance benefits, intermediaries use HCFA guidelines to determine the reasonable cost incurred by the individual providers in furnishing covered services to enrollees. The reasonable cost is based on the actual cost of providing such services, including direct and indirect costs of providers, and excluding any costs which are unnecessary in the efficient delivery of services covered by the insurance program.

- Recipient: A recipient of Medicaid is an individual who has been determined to be eligible for Medicaid and who has used medical services covered under Medicaid.

- Rural Health Clinic: A rural health clinic is an outpatient facility which is primarily engaged in furnishing physicians' and other medical and health services, which meets certain other requirements designed to ensure the health and safety of the individuals served by the clinic. The clinic must be located in an area that is not an urbanized area as defined by the Bureau of the Census and that is designated by the Secretary of DHHS either as an area with a shortage of personal health services, or as a health manpower shortage area, and has filed an agreement with the Secretary not to charge any individual or other person for items or services for which such individual is entitled to have payment made by Medicare, except for the amount of any deductible or coinsurance amount applicable.

- Skilled Nursing Facility (SNF): A skilled nursing facility is an institution which has in effect a transfer agreement with one or more participating hospitals, and which is primarily engaged in providing to inpatients skilled nursing care and restorative care services, and meets specific regulatory certification requirements.

- Skilled Nursing Facility Services: SNF services are all services furnished to inpatients of, and billed for by, a formally certified skilled nursing facility that meets standards required by the Secretary of DHHS.

- Spend-Down: Under the Medicaid program, spend-down refers to a method by which an individual establishes Medicaid eligibility by reducing gross income through incurring medical expenses until net income (after medical expenses) meets Medicaid financial requirements.

- State Buy-In: State buy-in is the term given to the process by which a State may provide Supplementary Medical Insurance coverage for its needy eligible persons through an agreement with the Federal government under which the State pays the premiums for them.

- State Plan: The Medicaid State Plan is a comprehensive written commitment by a Medicaid agency to administer or supervise the administration of a Medicaid program in accordance with Federal requirements.

- Supplemental Security Income (SSI): SSI is a program of income support for low-income aged, blind, and disabled persons established by Title XVI of the Social Security Act.

- Third-Party Liability: Under Medicaid, third-party liability exists if there is any entity (including other government programs or insurance) which is or may be liable to pay all or part of the medical cost or injury, disease, or disability of an applicant or recipient of Medicaid.

- Usual, Customary and Reasonable Charges: Method of reimbursement used under Medicaid by which State Medicaid programs set reimbursement rates using the Medicare method or a fee schedule, whichever is lower.

- Vendor: A medical vendor is an institution, agency, organization, or individual practitioner which provides health or medical services.